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Personal and Professional Development in Clinical Psychology

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This thesis is submitted in partial fulfillment
of the requirements for the degree of
Doctorate in Clinical Psychology

Coventry University, Faculty of Health and Life Sciences
University of Warwick, Department of Psychology

May 2015

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List of Abbreviations

5F-WEL	Five Factor Wellness Inventory
BACP	British Association for Counselling and Psychotherapy
BPS	British Psychological Society
CASP	Critical Appraisal Skills Programme
COSE	Counselor Self-Estimate Inventory
CSS	Counselling Skills Scale
DPCCQ	Development of Psychotherapists Common Core Questionnaire
ICRS	Interpersonal Communication Rating Scale
IPA	Interpretative Phenomenological Analysis
MBRP	Mindfulness-based Role Play
MeSH	Medical Subject Headings
MSQ	Minnesota Satisfaction Questionnaire
MULTI	Multitheoretical List of Therapeutic Interventions
NHS	National Health Service
OQ	Outcome Questionnaire
ORS	Outcome Rating Scale
OSI-R	Occupational Stress Inventory-Revised
PCOMS	Partners for Change Outcome Management System
PPD	Personal and Professional Development
QAC	Quality Assessment Checklist
SOS	Supervision Outcomes Survey
SPS	Session Progress Scale
SRS	Session Rating Scale
SSI	Supervisory Styles Inventory

SSQ	Supervisory Satisfactory Questionnaire
SWA	Supervisory Working Alliance
SWAI-T	Supervisory Working Alliance Inventory-Trainee
UK	United Kingdom
USA	United States of America
VTSS	Vanderbilt Therapeutic Strategies Scale

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Acknowledgements

I would especially like to thank the trainees that took the time to participate in this study. I really appreciate you sharing your experiences with me and letting me into your world. I value your bravery and I hope you feel the study goes some way to accurately reflecting your journey.

I would particularly like to thank my supervisors, Claudie Fox, Jacky Knibbs and Delia Cushway, for your expertise, guidance and encouragement. We all know that I could not have done this without you. I would also like to thank Lesley Pearson, Carolyn Gordon, Gwion Jones and Anne for your inspiration and support.

Thank you to my incredibly supportive friends and family who seem to believe in me no matter what. A particular thank you to: My mum & dad; Ellies, Ollie & Beth; The Maple-Fosters; Gandi & Jo; and Wendy, Steph, Becky & Flick. Having you all in my world makes me realise there is more to life than writing a thesis.

Finally, I would like to say an enormous thank you to Steve for being on this journey with me. Your patience and understanding has been exceptional. I could not have done this without you (and Panda).

Declaration

This thesis has not been submitted for any other degree or to another institution. It was conducted under the supervision of Dr Claudie Fox (Department of Psychology, University of Warwick), Jacky Knibbs (Clinical Psychologist, Coventry University) and Prof. Delia Cushway (Emeritus Professor of Clinical Psychology, Coventry University). The named supervisors were involved in developing the original research ideas and have provided suggestions and feedback throughout, including reading drafts of the chapters. Another colleague, familiar with interpretative phenomenological analysis, was involved in validating coding for my empirical paper. Apart from these collaborations, this thesis is my own work.

Chapters one and two of this thesis have been prepared for submission to the journal, *Clinical Psychology and Psychotherapy*, under the authorship of myself and the three research supervisors detailed above.

Summary

This thesis explores personal and professional development in clinical psychology. Over three chapters, various aspects of development throughout the career span are considered. Different forms of personal and professional development are addressed in relation to how development is understood, experienced, managed and evaluated.

The first paper investigates the impacts of supervision on psychological therapists, their practice and their clients. A systematic review of the literature since 2007 was conducted; this identified thirteen studies exploring various impacts of supervision. The paper focuses on developing an understanding of the processes and factors involved in supervision as well as the ways in which supervision has been beneficial or detrimental. While some evidence for the importance of supervision is indicated, the methodological challenges of researching this topic make it difficult to draw clear conclusions. Implications and suggestions for future research into supervision are described.

The second paper reports on an Interpretative Phenomenological Analysis study of trainee clinical psychologists' experiences of deciding whether to have personal therapy during training. Ten trainees took part in semi-structured interviews and three major themes emerged from their experiences. Conflicting ideas within the trainees' experiences were identified, relating to the purpose of therapy, whether therapy would make things better or worse and whether therapy was right for them. The findings are discussed with regard to how training providers can support trainees with the decision to have personal therapy.

The final paper is a reflective account of personal and professional development during clinical psychology training. The paper draws on findings from the preceding two papers as well as the author's personal experiences to emphasise the complexity of managing the tensions of developing different aspects of the clinical psychologist. Particular attention is paid to the importance of considering and developing 'the self' during training.

Overall Word Count: 19,939

Chapter 1: Literature Review

The impact of supervision on psychological therapists, their therapeutic practice and their clients

In preparation for submission to *Clinical Psychology and Psychotherapy* (See
Appendix A for author instructions for submission)

Overall chapter word count (excluding tables, figures and references): 7851

Abstract

Supervision is considered to be an essential component of the work of psychological therapists. However, there is a lack of empirical evidence to support this. This review aimed to further the current understanding of the impact of supervision on therapists, their practice and their clients. A systematic search was conducted of literature published since 2007. Thirteen studies met the inclusion criteria and were critically analysed using a Quality Assessment Checklist. Evidence for the impact of supervision on therapists and their practice was identified. The quality of the supervisory relationship was an important factor as to whether outcomes were constructive or detrimental. A link between supervision and client experience was explored but findings were inconclusive. Methodological limitations and the complexity of supervision research made it challenging to draw clear conclusions about the value of supervision. Future research should aim to work from a defined research agenda focused on evaluating a consistent definition of supervision that encompasses the diverse range of supervision processes and outcomes.

Key Practitioner Messages:

- The supervisory relationship can facilitate supervisee learning by providing a safe environment within which to develop.
- Processes and outcomes of supervision are complex and ever-evolving and require ongoing reflection and adjustment.
- Adopting a clear definition of supervision will facilitate evaluation and audit of the supervision process.

Keywords: Supervision, supervisee, clinical psychology, counselling, psychotherapy, systematic review

Introduction

Supervision in Clinical Psychology

Supervision plays an essential role in the professional development of clinical psychologists throughout their careers. Accordingly, the British Psychological Society's (BPS, 2014) *Division of Clinical Psychology Policy on Supervision* stipulates that clinical psychologists should be engaging in supervision, regardless of their career stage or their work context. Supervision is considered one of the essential components of clinical governance which aims to ensure that clients receive a safe and high quality service.

Supervision in clinical psychology is considered to consist of three types of supervision (BPS, 2014): operational/line management supervision primarily aims to ensure that the clinical psychologist is adequately fulfilling the needs of the service in which they work; professional supervision focuses on the development of the skills of the psychologist in line with professional standards; finally, clinical supervision relates to the maintenance and development of the clinical skills of the clinical psychologist. It is this aspect of supervision that will be explored in this review. Therefore, for the remainder of the review when the term 'supervision' is used, this refers to clinical supervision.

Supervision is not unique to the clinical psychology profession and is a consistent requirement amongst all psychological therapists. The British Association for Counselling and Psychotherapy's (BACP, 2013) *Ethical Framework* states the obligation for counsellors, psychotherapists, supervisors and trainers to have supervision. In fact, there is a lack of literature about supervision in clinical psychology leaving clinical psychologists reliant on the supervision literature

originating in the psychotherapy or counselling arena (Beinart, 2004). Therefore, in order to explore supervision in clinical psychology, it is necessary for this review to consider supervision in the wider arena of ‘psychological therapies’.

Supervision of Psychological Therapists

While there is general consensus amongst the therapeutic professions that supervision is an essential part of safe and effective practice, there is little agreement about the process and activities involved in supervision. Various models of supervision have been developed which shed some light on the expectations of the supervisory process (see Beinart, 2004, for a review). For example, developmental approaches (e.g. *Integrated Developmental Model*; Stoltenberg & Delworth, 1987) highlight the developmental stages that supervisees encounter in the process of becoming a competent clinician having mastered skills such as intervention skill competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans and professional ethics. According to this model, tasks for the supervisor vary according to the developmental stage of the supervisee.

On the other hand, the social role-based *Discrimination Model* (Bernard, 1997) describes the need for the supervisor to assume the roles of therapist, teacher and consultant in order to facilitate supervisee learning of therapy techniques, managing personal reactions to therapy work and formulation.

Alternatively, the *Systems Approach to Supervision* (Holloway, 1995) highlights the importance of the supervisory relationship within the context of the supervision. The model suggests that the supervisor monitors/evaluates, advises, models, consults and supports in order to achieve the five main skills of a counsellor

(counselling skills, case conceptualisation, professional role, emotional awareness and self-evaluation). The importance of the supervisory relationship in supervision is summarised by Holloway (1995), as quoted by Beinart (2004):

In the systems approach to supervision, relationship is the container of a dynamic process in which the supervisor and supervisee negotiate a personal way of using a structure of power and involvement that accommodates the supervisee's progression of learning. This structure becomes the basis for the process by which the supervisee will acquire knowledge and skills – the empowerment of the trainee. (p. 45)

Similarly, Bordin (1983) describes the importance of what he calls the 'supervisory working alliance' (SWA) which he suggests involves mutual agreement of the goals for supervision, the tasks of the supervisor/supervisee and the bond between the supervisor/supervisee with the aim of developing the necessary skills of the supervisee.

Finally, the *Seven-Eyed Process Model of Supervision* (Hawkins & Shohet, 2006) highlights a process of reflection on the client/supervisee interaction. Seven factors are considered important: How the client presents; strategies used by the supervisee; client/supervisee relationship; internal processes of the supervisee; the supervisory relationship; supervisor processes; and the wider context. This model successfully highlights the complex processes that are involved in supervision and the vast number of components that contribute to the experience for the client, supervisee and supervisor.

Many attempts to develop a coherent definition of supervision have been made. Initially, Bernard and Goodyear's (2004) definition was widely accepted:

Supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of the professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession. (p. 8)

However, this definition has since been challenged by Milne (2007) who suggests that supervision is:

The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s...Supervision's objectives are 'normative' (e.g. quality control), 'restorative' (e.g. encourage emotional processing) and 'formative' (e.g. maintaining and facilitating supervisees' competence, capability and general effectiveness). (p. 439)

As this definition includes supervisee development it was felt that Milne's definition would be most appropriate as the focus for this review.

The Impact of Supervision

Unfortunately, there is no one method of measuring the overall impact of supervision. According to the BPS's (2014) supervision policy, "The primary purpose of supervision is to ensure the safety and quality of care and treatment for service users" (p, 4). This would suggest that the most important measure of the effectiveness of supervision is client outcome, which Ellis and Ladany (1997) describe as the 'Acid Test'. This focus is also reflected in Bernard and Goodyear's (2004) definition.

However, as Milne (2007) highlighted there are considerably more supervision processes that may inadvertently affect clients, such as therapist emotional processing abilities. As a result, measures of outcome, other than client outcome, have also been considered, including the supervisee's self-reported satisfaction with supervision, supervisee self-efficacy, supervisee anxiety and the SWA (Wheeler & Richards, 2007). These methods of investigation are more in keeping with the normative, formative and restorative processes defined by Milne (2007).

In an attempt to gain some clarity about the empirical evidence for supervision, several systematic reviews of the literature have been conducted. One such review (Wheeler & Richards, 2007) was a systematic literature review of the impact of clinical supervision on counsellors and therapists, their practice and their clients. The benefit of this review is that it encapsulated a number of impact factors rather than limiting the review to one specific outcome, such as client outcome (e.g. Watkins, 2011).

The results of Wheeler and Richards' (2007) review indicated the growth and development of the supervisee as a result of supervision, highlighting impacts on

self-awareness, skills, self-efficacy and theoretical orientation. The study also highlighted the importance of the timing and frequency of supervision on the process and outcome of supervision.

Although the review offers some support for the direct impact of supervision on clients, the majority of studies in the review did not explore this. However, some of the findings relating to supervisee development, such as self-awareness relating to interactions with clients, could be expected to have a positive impact on the client.

The review highlighted the methodological challenges faced by researchers attempting to establish an evidence base for the impact of supervision. They highlight the general lack of definitions of supervision in the studies, the over-use of trainees, limited information on the participants included in the studies and the reliance on self-report measures. In addition, Wheeler and Richards (2007) highlighted the need for investigation into the long-term impacts of supervision as well as more rigorous studies, including Randomised Controlled Trials. Given the length of time since Wheeler and Richards' (2007) review, there is a need to update the literature to establish how more recent studies have explored the issue of how supervision impacts on therapists, their practice and their clients.

Rationale

Due to the financial pressures placed on psychological services at the current time, there is ever-growing need to evidence any activities that are being undertaken within the role. Pressures to prioritise activities that actually involve clients may challenge supervision practices, particularly when there is a lack of clear evidence to support the impact supervision has on clients. While the regulatory bodies that govern psychological therapists support the use of supervision, there is a need to

explore whether supervision is, in fact, beneficial or necessary. In addition, by developing a clearer understanding of the impacts of supervision, psychological therapists may be able to maximise efficiency of supervision and work with what they know works best.

Moreover, the BPS's (2014) supervision policy stipulates the importance of systematic auditing of supervision of its psychologists. However, in order for this process to be valid, a clearer idea of the aims of supervision is required.

Aims of the Review

This review aims to critically consider the literature in relation to the impact of supervision within psychological therapies. The review will critically evaluate the current research in the area in an attempt to develop an understanding of: which aspects of supervision have been considered; how they have been explored; with whom (therapists, supervisors, clients); and what impacts have been identified. This review will continue the work of Wheeler and Richards (2007) by exploring the impact of supervision on psychological therapists, their therapeutic practice and their clients.

The following questions will be explored:

1. What is the impact of supervision on psychological therapists?
2. What is the impact of supervision on psychology therapy practice?
3. What is the impact of supervision on the clients who receive psychological therapy?

Method

Search Strategy

Search terms were used based on their relevance to the question and synonyms were identified to capture all aspects of the term relevant to this review (Table 1.1).

Table 1.1

Systematic Review Search Terms

Concept	Variation	Location of Keyword
Supervision	Supervis*	Title only
Therapist	Counsel* Therap* Psychotherap* Clinical psycholog*	Abstract only
Impact	Outcome* Impact* Effect* Influence*	Article

*Note: Keywords were truncated (indicated with an *) to capture all variations of the term.*

Supervision, therapist and impact concepts were combined using the Boolean operator 'AND'.

A systematic literature search was completed, including literature from January 2006 to allow sufficient overlap between Wheeler and Richards' (2007)

search and the current search. Any articles that appeared before 2007 were screened to ensure they had not appeared in the previous review. Searches were completed in PsychInfo and MedLine databases in November 2014. MeSH (Medical Subject Headings) headings were used for counselling and psychotherapy when searching in MedLine. In addition, a manual search of relevant reference lists was conducted along with searches of relevant journals. All studies identified by the initial search were added to RefWorks (ProQuest LLC., 2009).

Inclusion and Exclusion Criteria

The review explored both quantitative and qualitative empirical research that had explored the impact of supervision. Discursive articles and case studies were excluded. In order to ensure that studies were able to inform the question, ‘what is the impact of supervision on psychological therapists, their therapeutic practice and their clients?’, criteria for inclusion and exclusion were identified. For further details of the inclusion and exclusion criteria of the study, see Appendix B. In order to develop the understanding of the various impacts of supervision, any impact that could conceivably affect the supervisor, their practice or their client was considered. Therefore, the criterion for ‘impact’ was deliberately not constrained to specific pre-determined outcomes.

In order to ensure that the selected studies informed the question regarding the impact of supervision on psychological therapists specifically, care was taken to only include therapists that matched this description, which included clinical psychologists, counsellors, therapists and psychotherapists. The professional was expected to have had professional training in psychological therapies and be engaging in a therapeutic relationship with clients. Therefore, other mental health

professionals (e.g. psychiatrists, nurses, social workers) that did not have experience of providing psychological therapy were excluded.

For the purposes of this review, studies were included if they explored supervision of face-to-face psychological therapy with individual clients. Therefore, studies were excluded if they exclusively explored supervision in relation to family therapy, group therapy, hypnotherapy, art therapy, music therapy, play therapy and yoga therapy, as it was felt that the supervision of these types of therapy are frequently distinctly different from that of supervision relating to more traditional psychological therapies and was, therefore, outside the scope of this review.

The scope of this review was limited to individual supervision. Although, group supervision was included in Wheeler and Richards' (2007) review, it was felt that this style of supervision presented a distinctly different dynamic that would warrant specific investigation. Therefore, supervision that involved more than one supervisee was excluded.

Systematic Search Results

The systematic search identified 666 articles, leaving 576 articles when duplicates were removed (see Figure 1.1 for an overview of the systematic search strategy). Any studies that were clearly related to physical health or patients being supervised as part of a physical health intervention were removed as a result of a title screening.

The remaining 319 studies relating to supervision of professionals were then initially included or excluded on the basis of reading the titles and abstracts. In the case that further clarity was required, a decision was deferred until the full text article had been obtained. At this stage, 306 studies were excluded as they did not fit

the inclusion criteria. A number of studies are represented more than once as they were excluded for multiple reasons.

As a result of the systematic process, thirteen studies were identified as relevant to the question of how supervision impacts on psychological therapists, their therapeutic practice and their clients.

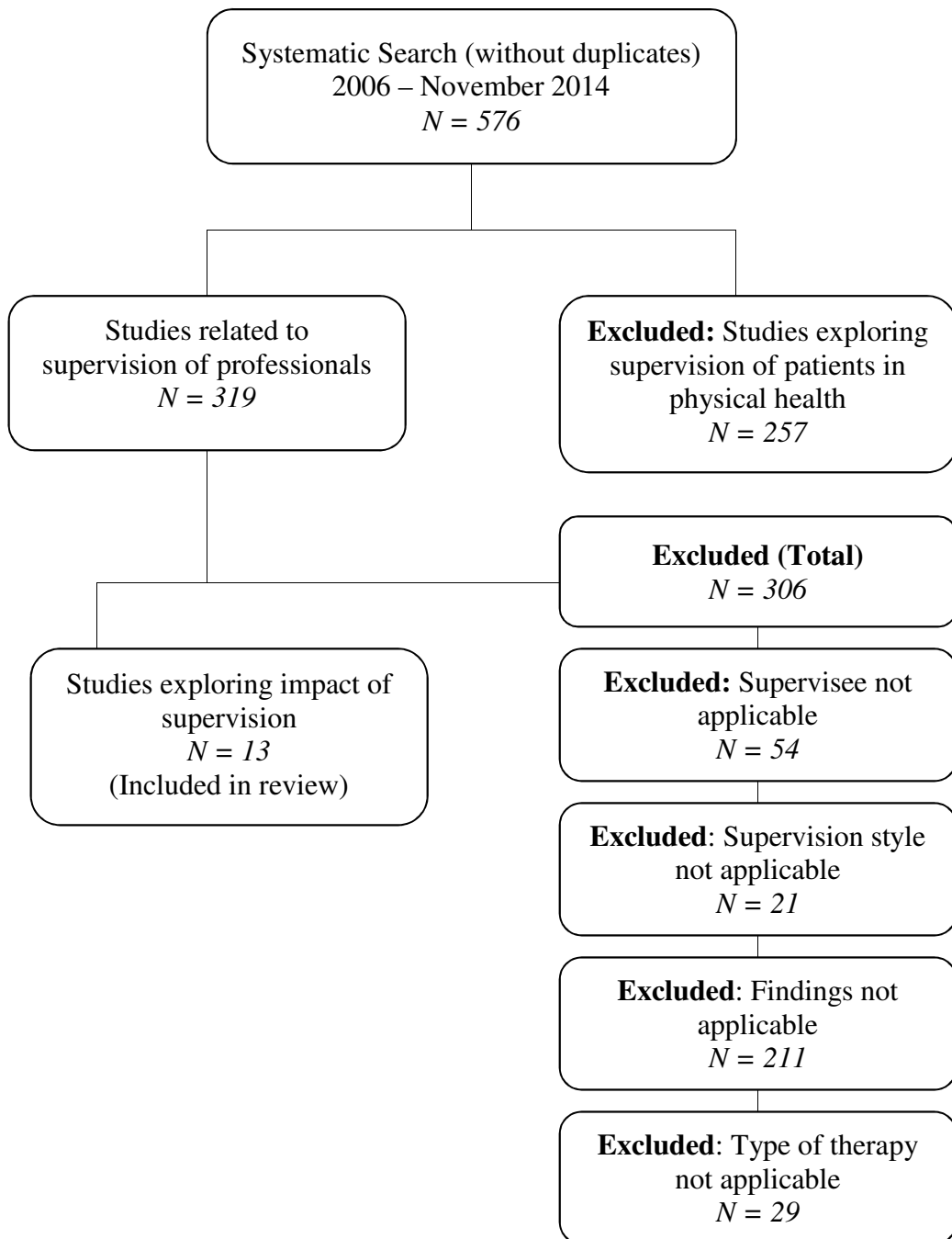


Figure 1.1. Systematic search strategy

Assessment of Quality

In order to assess the quality of the thirteen identified studies, a Quality Assessment Checklist (QAC; Appendix C) was developed with consultation from Caldwell, Henshaw and Taylor's (2005) *Research Critique Framework*, the Critical Appraisal Skills Programme (CASP; 2013) *Qualitative Research Checklist* and Downs and Black's (1998) *Checklist for Measuring Study Quality*. Items were selected specifically relating to the criteria that were being considered in this review.

Quantitative and qualitative studies were assessed separately. For each paper, each criterion was rated as being fully met (Yes), partially met (Partially), not sufficiently met (No) or it was not possible to assess (Can't tell). Total and percentage scores were calculated for each paper (see Appendix D). Papers were not excluded at this stage based on quality. However, the results of the studies were considered in light of the strengths and limitations highlighted by the QAC. Although this approach is not inline with the usual systematic process, it was felt that it was important to recognise the common methodological limitations of the studies and explore them discursively.

Results

A summary of the thirteen studies included in this review can be found in Table 1.2. Six of the thirteen studies adopted qualitative methodologies and seven used quantitative methodologies. Ten studies were conducted in the USA, two in the UK and one in Australia. Quality ratings for the studies varied with the qualitative studies generally scoring higher than the quantitative studies.

Table 1.2.
Summary of Characteristics of the Reviewed Studies

Authors	Aims of the study	General research approach	Sample information	Research tools	Results relating to the impact of supervision	Quality Rating
Ancis & Marshall (2010)	To explore supervisees' experience of supervision relating to multicultural issues.	<i>Qualitative</i> Constant Comparative Methodology – Grounded Theory	<i>Supervisees</i> 4 clinical and counselling psychology doctoral students 2 males, 2 females Indicated an interest in multicultural issues and rated their supervisor as satisfactorily addressing multicultural issues in supervision	Semi-structured interviews	<ul style="list-style-type: none"> Supervision supported therapist awareness of multicultural issues. Supervision enhanced understanding of client from a cultural perspective. Link between multicultural discussions in supervision and discussions in therapy. 	71%
Anderson, Crowley, Patterson & Heckman (2012)	To identify the effectiveness of psychotherapy supervision on therapists' adherence to time-limited dynamic psychotherapy.	<i>Quantitative</i> 3 cohorts, repeated measures design	<i>Supervisees</i> 16 psychotherapists (8 psychologists, 8 psychiatrists) 10 males, 6 females <i>Clients</i> 48 patients with interpersonal difficulties	<i>Adapted Vanderbilt Therapeutic Strategies Scale</i> (VTSS; Butler, Henry & Strupp, 1995) - Supervisory adherence. <i>VTSS-Therapy</i> (Butler et al., 1995) - Therapy adherence. <i>Vanderbilt Psychotherapy Process Scale</i> (O'Malley, Suh & Strupp, 1983) - Relational processes.	<ul style="list-style-type: none"> Supervisors' comments about specific techniques predicted how the therapist would adhere to techniques in the next therapy session. 	61%
Andersson, King & Lalande (2010)	To explore therapists' experience of mindfulness-based role play (MBRP) supervision and the impact on therapists' empathy towards the client.	<i>Qualitative</i> Consensual Qualitative Research	<i>Supervisees</i> 13 'therapists' 4 psychologists 4 counsellors 1 psychotherapist 1 social worker 1 mental health nurse 1 art therapist	Semi-structured interviews	<ul style="list-style-type: none"> Increase in therapist's awareness of functioning. Observed effects in therapy. Increased empathy towards client. 	75%
Grossl, Reese, Norsworthy & Hopkins	To determine whether the use of client feedback data	<i>Quantitative</i>	<i>Supervisees</i> 44 clinical/counselling	Outcome Rating Scale (ORS; Miller & Duncan, 2000)	<ul style="list-style-type: none"> More satisfaction with supervision when client feedback was used in 	46%

(2014)	in supervision influences supervisory process and treatment outcome.	Comparison of two groups	psychology masters students or marriage and family master students or counselling psychology doctorate students 18 men, 26 women <i>Supervisors</i> 18 psychologists or marriage and family therapists <i>Clients</i> 138 (79 women, 59 men)	Client progress in therapy. <i>Supervisory Satisfaction Questionnaire</i> (SSQ; Ladany et al., 1996) Supervisees' satisfaction with supervision. <i>Supervisory Working Alliance Inventory – Trainee Version</i> (SWAI-T; Efstation, Patton & Kardash, 1990) - Supervisory working alliance.	supervision. • No difference in supervisory working alliance in the two groups. • No differences in client outcome between groups.	
Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley & Hoffman (2008)	To explore pre-doctoral interns' experience of disclosure.	<i>Qualitative</i> Consensual Qualitative Research	<i>Supervisors</i> 9 female, 5 male <i>Supervisees</i> 14 pre-doctoral interns 11 women, 3 men • 13 counselling psychology PhD students • 1 clinical psychology student	Semi-structured interviews Questionnaires to assess context – good or problematic relationship: <i>Supervisory Styles Inventory</i> (SSI; Friedlander & Ward, 1984) - Perception of a supervisor's style. <i>Supervisory Satisfaction Questionnaire</i> (SSQ; Ladany et al., 1996) - Perceived satisfaction with supervision.	Negative effects of non-disclosure in supervision in the context of a poor supervisory relationship • Loss of confidence, guilt, embarrassment. • Less likely to disclose in future. Impact on client work • Less helpful to clients. • Poorer therapeutic relationships. • Increased anxiety.	71%
Knox, Burkard, Edwards, Smith & Schlosser (2008)	To explore supervisors' perceptions of the causes and effects of supervisor's use of self-disclosure in supervision.	<i>Qualitative</i> Consensual Qualitative Research	<i>Supervisors</i> 16 supervisors • 11 counselling psychologists • 3 clinical psychologists • 2 counsellor educators 9 men, 7 women	Demographic form Two semi-structured interviews	• Disclosure enhanced supervisee learning. • Positive impacts on the supervision relationship. • Disclosure relaxed the supervisee.	75%
Lenz, Sangganjanavanich, Balkin, Oliver & Smith (2012)	To explore the effectiveness of the Wellness Model of Supervision for developing wellness constructs among counsellors-in-training compared to alternative models of supervision.	<i>Quantitative</i> Quasi-experimental within-subjects	<i>Supervisees</i> 32 masters level counselling students 24 female, 8 male	Open ended Questionnaire – Personal definition of wellness <i>Five Factor Wellness Inventory</i> (5F-WEL; Myers & Sweeney, 2004) - Supervisee wellness. <i>Counselling Skills Scale</i> (CSS; Eriksen & McAuliffe, 2003) – Supervisee development.	• Increase in comprehensiveness of Personal Wellness construct and Total Wellness in participants that received the Wellness Intervention. • Counselling skill development was similar in the two groups.	64%
McAleavey, Castonguay & Xiao (2014)	To explore the relationship between therapist's	<i>Quantitative</i>	<i>Supervisees</i> 16 trainee psychotherapists	<i>Multi-theoretical List of Therapeutic Interventions</i> (MULTI; McCarthy &	• Clients found therapy sessions more helpful when the therapist and	54%

	theoretical orientation, supervisor's theoretical orientation and therapy techniques on psychotherapy session outcome.		8 male, 8 female <i>Clients</i> 31 comorbid clients with an average 2.7 of diagnoses per client: <ul style="list-style-type: none"> • 28 diagnosed with Axis I diagnosis • 25 diagnosed with Axis II diagnosis 	Barber, 2009) – Measure of therapist behaviours in therapy session. <i>Session Progress Scale</i> (SPS; Kolden, 1996) – Client-rated session quality (helpfulness). <i>Development of Psychotherapists Common Core Questionnaire</i> (DPCCQ; Orlinsky et al., 1991) - Measure of therapist and supervisor orientation.	supervisor were both affiliated with cognitive therapy techniques. <ul style="list-style-type: none"> • Clients found sessions less helpful when the supervisor and therapist did not match on cognitive therapy orientation. 	
Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands & Chisholm (2009)	To investigate whether using client feedback in supervision impacts on client outcome, supervisory working alliance, satisfaction with supervision and counsellor self-efficacy.	<i>Quantitative</i> Between-groups (client feedback or no client feedback)	<i>Supervisees</i> 28 masters students <ul style="list-style-type: none"> • 19 marriage or family therapy • 9 clinical-counselling psychology <i>Supervisors</i> 9 masters faculty staff <i>Clients</i> 95 clients experiencing mood, anxiety disorders, relationship or marital problems, grief variety of Axis I and Axis II disorders.	<i>Outcome Rating Scale</i> (ORS; Miller & Duncan, 2000) - Client progress in therapy. <i>Session Rating Scale</i> (SRS; Miller, Duncan & Johnson, 2000) - Client-rating of therapeutic relationship. <i>Supervision Outcomes Survey</i> (SOS; Worthen & Isakson, 2003) - Supervisees' satisfaction with supervision process. <i>Supervisory Working Alliance Inventory – Trainee Version</i> (SWAI-T; Efstation, Patton & Kardash, 1990) - Supervisory working alliance. <i>Counsellor Self-Estimate Inventory</i> (COSE; Larson et al., 1992) - Counsellor self-efficacy.	<ul style="list-style-type: none"> • No impact of receiving client feedback on experience of supervisory relationship or satisfaction with supervision. • No impact of receiving client feedback on counsellor self-efficacy. 	68%
Spence, Fox, Golding & Daiches (2014)	To investigate use of self-disclosure in supervision in order to develop an understand of self-disclosure processes.	<i>Qualitative</i> Constructivist Grounded Theory	<i>Supervisees</i> 10 clinical psychologists	Open-ended interviews	<ul style="list-style-type: none"> • Impact of supervisory relationship on self-disclosure. • Experience of the supervisory relationship impacted by non-disclosure. 	83%
Starr, Ciclitira, Marzano, Brunswick & Costa (2013)	To explore the meanings of supervision and the impact of supervision on clinical counselling practice.	<i>Qualitative</i> Thematic analysis	<i>Supervisees</i> 19 psychological therapists	Semi-structured interviews	<ul style="list-style-type: none"> • Feeling supported in managing conflicting experiences. • Feelings of empowerment. • Increase in knowledge. 	88%

Sterner (2009)	To identify perceptions of supervision and to explore how supervision influences work satisfaction and work-related stress.	Quantitative Cross-sectional	Supervisees 71 counsellors	<p><i>Supervisory Working Alliance Inventory – Trainee</i> (SWAI-T; Efstation, Patton & Kardash, 1990) - Supervisee perceptions of the clinical supervision relationship.</p> <p><i>Minnesota Satisfaction Questionnaire–Short Form</i> (MSQ; Weiss, Dawis, England & Lofquist, 1967) - Supervisee work satisfaction.</p> <p><i>Occupational Stress Inventory-Revised</i> (OSI-R; Osipow, 1998) - Work-related stress.</p> <p>Demographic Questionnaire – To identify those that did not meet the exclusion criteria.</p>	<ul style="list-style-type: none"> When SWA was perceived as strong, work-related stress was decreased. Supervisees who were more satisfied with their supervision were more satisfied with their work. 	50%
Tracey, Bludworth & Glidden-Tracey (2012)	To examine the interaction patterns (parallel processes) in supervision triads and explore whether there is any client outcome related to parallel processes	Quantitative Repeated measures	<p>17 Supervision triads</p> <p><i>Supervisees</i> 7 therapists – first practicum of master’s degree in counselling</p> <p><i>Supervisors</i> 3 female</p> <p><i>Clients</i> 17 (13 female, 4 male) – depression, interpersonal/relationship difficulties and anxiety</p>	<p><i>Outcome Questionnaire-45</i> (OQ; Lambert et al., 1996) - Client distress.</p> <p><i>Interpersonal Communication Rating Scale</i> (ICRS; Strong, Hills & Nelson, 1988) - Rating of interpersonal interaction during therapy & supervision (Rated using computer Joystick apparatus and program; Sadler et al., 2007).</p>	<ul style="list-style-type: none"> Parallels were noted between supervisor’s behaviour in supervision and therapist behaviour in subsequent therapy session. The more the therapist replicated their supervisor’s behaviour, the more positive the client outcome. 	36%

Overview of Results

Of the thirteen studies, seven focused on supervisee-reported outcomes. They explored specific types of supervision such as adopting a multicultural focus (Ancis & Marshall, 2010) and using Mindfulness (Andersson, King & Lalande, 2010) or Wellness (Lenz, Sangganjanavanich, Balkin, Oliver & Smith, 2012) approaches. In addition, supervision processes and the impact this has on the supervisee were considered, including the impact of non-disclosure (Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley & Hofman, 2008; Spence, Fox, Golding & Daiches, 2014) and the supervisory relationship (Spence et al., 2014; Starr, Ciclitira, Marzano, Brunswick & Costa, 2013; Sterner, 2009).

Studies that primarily focused on supervisees tended to explore impacts such as work-related stress (Sterner, 2009), supervisee development (Ancis & Marshall, 2010; Starr et al., 2013), changes in supervisees' experience of their client (Ancis & Marshall, 2010; Andersson et al., 2010), negative feelings or experiences (Hess et al., 2008) and self-disclosure (Spence et al., 2014).

One of the studies (Knox, Burkard, Edwards, Smith & Schlosser, 2008) explored supervision outcomes from the perspective of the supervisor by asking supervisors about their experiences of the impact of disclosing to their supervisees in supervision.

Five studies adopted a triangulation approach and aimed to explore direct links between supervision processes and client impact. Supervision processes explored included utilising client feedback data (Grossl, Reese, Norsworthy & Hopkins, 2014; Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands & Chisholm, 2009), discussions relating to specific therapy techniques (Anderson, Crowley, Patterson & Heckman, 2012) and observed parallel processes (Tracey,

Bludworth, & Glidden-Tracey, 2012). One study (Mcaleavey, Castonguay & Xiao, 2014) explored the impact of therapist-supervisor theoretical orientation match on therapy with clients.

Three of the triangulation studies measured client outcome directly (Grossl et al., 2014; Reese et al., 2009; Tracey et al., 2012). The other two explored the impact of supervision on the therapy session, specifically client-rated session helpfulness (Mcaleavey et al., 2014) and use of therapy techniques in the therapy session (Anderson et al., 2012).

Supervision Activity

Supervisors. The available evidence makes it challenging to develop a sense of the studies' supervisor characteristics. Two studies (Knox et al., 2008; Tracey et al., 2012) reported years experience as a supervisor (5-35 and 10 years, respectively). Supervisors generally had doctorate degrees in counselling psychology, clinical psychology or marriage and family therapy. Supervisor-supervisee theoretical orientation match was not detailed with the exception of Starr et al.'s (2013) study as this was the primary focus. Only one study (Knox et al., 2008) reported whether supervisors had undertaken any supervision-specific training.

Supervisees. Although, males and females were represented in nine of the studies, there was a bias towards female supervisees as participants. Eight studies recruited trainee participants, including counselling/clinical psychology doctorate students and counselling/clinical psychology/marriage and family therapy masters students. Supervisee age was reported in nine studies (age range = 20-73).

The general theoretical orientation of the therapists included psychodynamic, cognitive-behavioural, interpersonal, eclectic/integrative, feminist, person-centered, humanistic and systemic. However, the extent to which therapist orientation dictated the therapeutic approach was unclear and this information was not reported in six of the studies.

Clients. Eight of the studies did not report any information relating to clients, with the presenting problem of the clients most commonly reported. Clients presented with mood and anxiety disorders, relationship difficulties and a variety of Axis I and Axis II disorders (Diagnostic and Statistical Manual of Mental Disorders, Version 4-TR; American Psychiatric Association, 2000). Age of clients was only reported in three studies (age range = 18-69).

Supervision processes. There is generally a lack of information regarding supervision processes, the models that inform supervision or the frequency/duration of supervision. Therefore, it is challenging to establish from the studies what occurs in supervision of psychological therapists. For example, only one study (Starr et al., 2013) asked their participants to describe the orientation of their supervision.

Anderson et al. (2012) provided a summary of the ‘traditional’ supervision processes that they explored, including presentation of client background, reviewing audio-taped sessions and supervisors emphasising interventions that would be client-appropriate. Similarly, Reese et al., (2009) described the process of supervision including updates on caseload, discussing audio/video recordings of client sessions, discussing concerns and exploring the supervisees’ goals.

Other studies tended to only describe aspects of supervision that were directly being investigated. For example, Andersson et al. (2010) described the use of a ‘dialogical mindfulness’ approach in supervision which involved exploring

mindful awareness within the context of a dialogue between two people, which, in the case of the study, was a role-played interaction between the supervisee as therapist and the supervisee as the 'client'.

Similarly, Lenz et al. (2012) detailed the Wellness Model of Supervision which aims to facilitate development and evaluation of a personalised wellness plan with the aim of promoting wellness during training. However, the 'alternative models of supervision' that were compared to the Wellness Model were not described.

In contrast, a multicultural approach to supervision was explored in Ancis and Marshall's (2010) study using Ancis and Landany's (2001) model, which describes five processes of multicultural supervision. These support supervisees to develop self-awareness, understanding of client contextual issues and explore diverse approaches to client working.

Supervision activities. A number of studies explored novel or specific activities that occur within supervision. Grossl et al., (2014) and Reese et al., (2009) explored the use of client feedback data in supervision. The Partners for Change Outcome Management System (PCOMS) measures client-rated progress and therapeutic relationship and the data is then reviewed in supervision.

A number of studies considered the process of disclosure within supervision. Knox et al. (2008) explored the use of supervisor self-disclosure. Supervisors self-disclosed if their supervisees were struggling with their emotional reactions to clients or feeling stuck. The self-disclosure itself involved sharing emotional reactions towards clients and therapy experiences. Supervisors aimed to teach or enhance supervisee development, normalise their supervisees' experiences, strengthen the relationship or increase supervisee disclosure in supervision.

Several studies also highlighted the process of supervisee nondisclosure. Trainee therapists in Hess et al.'s (2008) study typically refrained from disclosing for fear of the consequences or feelings of insecurity or embarrassment. Similarly, clinical psychologists in Spence et al.'s 2014 (2014) study cited the clinical psychology culture as a cause of their resistance to self-disclose as they felt that self-disclosure could be interpreted as evidence of them struggling.

One study explored the link between the supervision relationship and the therapeutic relationship, through parallel processes. Tracey et al. (2012) presented evidence for parallel processes in psychotherapy supervision, which occur when the therapeutic relationship is unconsciously replicated in the supervision dynamic. The results of the study suggested that supervisees were inclined to behave in supervision in a manner that replicated the behaviour of their client in the proceeding therapy session. Evidence was also found for supervisors replicating the therapist's behaviour in the proceeding therapy session.

The Impact of Supervision on Therapists

The impact on development and learning. The impact of supervision on therapist development and learning was one of the key outcomes from the studies. The therapists in Starr et al.'s (2013) qualitative study described feeling empowered by gaining new knowledge and exploring things from a new perspective in supervision. Participants experienced both stimulation and discomfort as a result of this process. The study suggests that the 'safe' environment of supervision provides an opportunity to experience and manage the necessary tensions involved in supervisee development.

Starr et al.'s (2013) study created a cohesive experiential supervision model which captures the complexity of the experiences of development within supervision. Having presented a clear account of the researchers' reflexivity and the qualitative research process, this study rated highest on the Quality Assessment Checklist (QAC; See Appendix C). However, as all the participants in the study were counsellors based in a specific women's therapy centre and little information relating to the clients receiving therapy was presented, it is unclear how far these results apply to other settings.

The therapists in Andersson et al.'s (2010) qualitative study described learning through supervision in the form of an enhanced awareness of their functioning as therapists. Following an experience of supervision including dialogical mindfulness role-play, the therapists described being both more aware of areas of functioning in which they felt competent, and areas in which they felt they were lacking.

This study describes a creative approach to supervision that was valued by the participating therapists. However, this study received a low rating on the QAC, compared to other qualitative studies in the review. As the study only explored a one-off mindfulness supervision experience, it is unclear as to the longer-term impacts of using mindfulness approaches in supervision. Additionally, adherence to the mindfulness supervision protocol was not assessed, which queries whether the supervision experience was consistent with the standard protocol. It is also worth noting that the participants in the study varied in terms of their previous experience with mindfulness. It is possible that this may have impacted on their experiences. As the authors note, the participants who opted to take part may have a particular interest in mindfulness approaches. Therefore, exploring this approach with novice

therapists would allow the style of supervision to be considered within a wider context. It is also worth noting that the authors did not comment on the potential bias that they may have brought to the research process.

Increased client understanding was also found as a learning outcome of supervision. Ancis and Marshall (2010) explored psychology doctoral students' experience of supervision that they perceived to be culturally-competent. The supervisees described supervision encouraging them to develop an understanding of their client within the context of the client's unique diversity. In addition to increased client understanding, participants highlighted an increased awareness of their personal multicultural issues and the potential impact on their client work.

This study emphasises how supervision can support supervisees with cultural aspects of their work, which is arguably a valuable use of supervision time. However, it is worth noting that the study only explored supervision that effectively considered multicultural issues. Therefore, the study is not necessarily representative of the majority of supervision sessions that occur within psychological therapies. It is also noteworthy that the influence of the researcher in the data collection and analysis was not fully considered in the paper. This may have been a particularly important aspect of this study given that it was aiming to further a model that the authors had been involved in developing. As a result of these methodological restrictions, the study was rated as one of the lowest by the QAC.

The one study that explored supervision from the supervisor's perspective considered supervisee learning that resulted from supervisors' use of self-disclosure (Knox et al., 2008). The supervisors felt that by self-disclosing they enhanced supervisees' learning and elicited a sense of relief and relaxation in their supervisees.

The study also highlighted reports of supervisee self-disclosure having positive effects on the supervision relationship by increasing comfort within the relationship.

While it is interesting to explore supervision from the supervisor's perspective, the study may also have benefitted from exploring the views and experiences of the supervisees involved in the interactions. It should also be noted that Knox et al. (2008) experienced a challenge when recruiting for this study, resulting in a number of the participants being associated with the researcher. As the authors note, it is possible that this may have impacted on participant responses. The study did not adequately consider the ethical implications of the study, which would have been valuable given the potential link between participant and researcher. However, this study was rare as it included the interview protocol, a detailed account of the data analysis methods and thorough consideration to potential author biases. This represents a transparent approach which is a credit to the study.

In contrast to Knox et al.'s (2008) study, Spence et al. (2014) explored clinical psychologists' experiences of disclosing to their supervisors. Both positive and negative experiences were reported by the supervisee, including the disclosure facilitating a process of change, providing validation but also creating a sense of awkwardness and discomfort resulting from a disclosure.

Spence et al.'s (2014) study provides a rare insight into the experiences of clinical psychologists in supervision. As a clinical psychology trainee herself, the researcher aptly considered her position in relation to the research and her approach to reflexivity was thoroughly described. However, as the type of supervision being conducted was not clear in the study, it is not possible to gather a clear sense of the context in which the disclosures were taking place. Some participants highlighted the difficulties of having combined managerial and clinical supervision, which suggests

that supervision fulfilled multiple purposes for the psychologists. Overall, the study scored highly on the QAC.

One study in the review highlighted the losses that supervisees can experience as a result of a negative supervision experience (Hess et al., 2008). Doctorate-level psychology students described a loss of confidence, embarrassment and doubts about their competency as a result of not disclosing to supervisors in supervision.

The impact on disclosure. One of the impacts that was explored in a number of the studies was the impact of supervision on supervisee disclosure within supervision. This factor highlights the complexity of the supervision process with aspects of supervision itself impacting on the supervisee's behaviour in subsequent supervision sessions. Hess et al. (2008) found the quality of the supervisory relationship to be an important moderator for whether supervisees self-disclose to their supervisors. The study compared the impact of supervisee non-disclosure in both 'good' and 'problematic' supervision relationships. Although supervisees in 'good' relationships described concerns about having not disclosed, they did not perceive negative impacts on the relationship with their supervisor.

In contrast, supervisees with problematic supervisory relationships tended to experience the nondisclosure negatively (feelings of disappointment, frustration, not feeling safe within the relationship and becoming less likely to disclose in future). This study suggests a process in which the quality of the supervisory relationship and non-disclosure within supervision interact in a cyclical pattern, potentially creating ongoing difficulties within the supervision process.

However, it could be argued that separating supervisory relationships into 'good' and 'bad' and only considering one specific disclosure event within this

relationship may have limited the scope of the study. This study scored one of the lowest on the QAC with lowest scores resulting from limited contextual information.

Spence et al. (2014) also highlighted positive impacts of a 'compatible' supervisory relationship on supervisee disclosure. They found that supervisees were more likely to feel able to self-disclose to their supervisor if there was a level of compatibility between the supervisor's and supervisee's theoretical orientations. The study also found that an interpersonal connection characterised by trust, warmth and collaboration facilitated an environment in which supervisees felt that they could disclose.

The impact on coping and wellbeing. The role of supervision in the management of supervisee stress and wellbeing has been identified as an important factor. Sterner (2009) explored the effect of the quality of the SWA on supervisees' perception of their work. Supervisees that rated their SWA with their supervisor positively indicated greater satisfaction with their work and less work-related stress.

However, the methodological challenges encountered by this study resulted in a QAC rating of 50%. As some of the counsellors in the study were not currently receiving supervision, their impressions were based on retrospective experiences. Additionally, a poor response rate of 20% raises concerns about the participants representing a distinct population of counsellors. It was also not possible to explore the impact of a poor SWA as insufficient numbers of counsellors reported poor relationships.

Lenz et al. (2012) explored a specific aspect of supervisee wellbeing by exploring the impact of a Wellness supervision intervention on trainee counsellors. The intervention involved development and ongoing evaluation of a personalised wellness plan. As predicted, participants that received wellness supervision

developed more comprehensive constructs of personal wellness. This was reflected in an increase in wellness in the group that had received the Wellness intervention, when compared to a decrease in wellness in the group that received alternative models of supervision.

This study was one of the highest rated quantitative studies in the review. However, a small sample size and uncertainty about whether the measures of wellness, represented actual change in wellness bring the findings into question. In addition, allocation of intervention was completed based on counsellor location, which questions whether the two groups were comparable. As with many studies in the review, Lenz et al. (2012) do not detail the alternative models of supervision to which the wellness model was being compared.

The Impact of Supervision on Therapists' Therapeutic Practice

The direct impact of supervision on supervisees' behaviour in subsequent therapy sessions was explored by Anderson et al. (2012). They found that supervisor comments relating to specific, manualised, time-limited dynamic psychotherapy techniques would predict how well the therapist used the techniques in the subsequent therapy session. However, it was noted that the supervision session did not alter the relational processes that occurred in therapy, which suggests that technique adherence may be more easily affected by supervision, compared to relational processes.

This study appears to demonstrate the session-to-session effects of supervision. However, the study does not provide evidence for longer-term supervision impact and it is possible that the findings may not extend beyond manualised therapies. Additionally, the complexity of the study design creates a

challenge in accurately interpreting the findings, which unfortunately reduces the clinical application of the findings.

The link between supervision and therapy sessions was also noted by Tracey et al. (2012). They found that supervisor behaviour in supervision was replicated by their supervisees in subsequent therapy sessions. Unfortunately, the complexity of the study design makes it challenging to draw clear conclusions about the applicability of this study to real-world supervision sessions. Only twenty minutes of a therapy session were used to rate supervisee behaviour and the amount of missing data makes it challenging to draw clear conclusions.

Impact of supervision on practice was also evidenced by Ancis and Marshall (2010) who found that culturally-competent supervision encouraged therapists to advocate for their clients. They described being more able to facilitate the client's understanding of their social issues and discuss issues relating to client diversity. However, as previously noted, the only therapists in the study were those that had received supervision that was deemed to effectively explore multicultural issues.

Similarly, Andersson et al. (2010) found an increase in therapist empathy towards their client following use of dialogical mindfulness role-play in supervision. Participants described an increase in understanding of their client's situation and gained new insights into how to progress with the client. Unfortunately, it is unclear how the research topics were explored with the participants as the authors do not include any information relating to their interview schedule.

However, negative impacts of supervision on practice have also been found. Supervisees in Hess et al.'s (2008) study described their impression of the impact of non-disclosure on the therapy they provide. Supervisees reported feeling more anxious, less helpful and less present during therapy. They also noted nondisclosure

reducing how they perceived the quality of the client-therapist relationship. However, exploring the client's experience of the relationship would have been beneficial.

The Impact of Supervision on Clients

The impact of supervision on clients was explored in a number of the studies. Reese et al. (2009) compared supervision that included reviewing client feedback data to supervision as usual. The authors predicted that using client feedback data in supervision would improve the supervisory relationship, supervisee satisfaction with supervision and counsellor self-efficacy, thus resulting in improved client outcome. However, although use of client feedback was associated with improved client outcome, it was not related to the supervision factors. This suggests that client outcome may not be directly linked to an improvement in supervisory relationship.

This study highlights the problems associated with using trainee therapists as the study captured an increase in self-efficacy in all students over time as you would expect with a developing trainee population. Interestingly, it is also worth noting that client outcome was partly assessed by client-rated therapeutic relationship quality. While therapeutic relationship is a valuable factor to consider, it may have been valuable to separate client progress from their experience of the therapy relationship. Despite the methodological critique, this study was rated as the highest of the quantitative studies by the QAC.

Contrastingly, Grossl et al. (2014) found no impact of using client feedback data in supervision on client outcome. However, they did find that supervisees who used client feedback data in supervision reported more satisfaction with their supervision. This highlights the importance of not assuming that clients will improve

if therapists consider their supervision to be effective. It is also worth noting that there was no difference in supervisory alliance score between the two groups. It is probable that the differences in the findings of these studies are accounted for by the different methodological approaches that they adopted. In Grossl et al.'s (2014) study, adherence to the client feedback condition was unreliable, which creates doubts as to whether there was a significant difference between the two groups' use of client feedback. Additionally, clients in this study were only required to have had two sessions of therapy in order to be included, which may not be a realistic expectation of client improvement. Also, it is questionable whether it is valid for supervisees to only complete measures relating to their experience of supervision once the relationship has ended.

One study (Mcaleavey et al., 2014) aimed to measure the effectiveness of supervision by asking clients to rate therapy session quality/helpfulness. Clients rated cognitive therapy sessions as more helpful when the therapist and supervisor were both competent and comfortable with the approach. If there was a mismatch in which either therapist or supervisor were not affiliated with cognitive therapy, the session quality was rated lower. They also found that when supervisors were highly psychodynamically orientated and the therapy predominately used psychodynamic therapy technique, the sessions were rated as less helpful.

However, as the authors note, post-session rating of session usefulness may not be the most reliable measure of overall therapy effectiveness. Additionally, therapists appeared to self-rate the extent to which they used particular techniques during the therapy session, which may not be an accurate way to measure therapist behaviour.

Finally, Tracey et al. (2012) explored the impact of parallel processes on client-rated distress. The more therapists acted like their supervisors had done in the previous supervision session (parallel process), the better the outcome for the client. However, as previously noted, it is not possible to draw accurate conclusions from this study.

Discussion

Summary of Main Findings

This review highlights the complexity of the issues regarding the impact of supervision on psychological therapists, their therapeutic practice and their clients. The questions that the review aimed to address appeared to be straightforward: What is the impact of supervision on psychological therapists? What is the impact of supervision on therapy practice? What is the impact of supervision on the clients who receive psychological therapy? However, the inevitable challenges of exploring this topic became apparent as the review progressed. This is not the first time that the complexity of supervision research has been noted (Wampold & Holloway, 1997). Supervision is an enormous topic that includes a significant number of variables.

As a result of this complexity, the literature reviewed here is understandably fragmented. For example, one study explored the impact of supervision on doctorate students' awareness of multicultural issues (Ancis & Marshall, 2010), while another considered the impact of supervisors' use of disclosure in supervision from the perspective of the supervisor (Knox et al., 2008). While the studies contribute to a piece of the picture, it is challenging to establish an overall conclusion of the impact of supervision from the literature reviewed here.

Despite this, the results of the review offer some useful information to help inform the questions around the impacts of supervision. A number of impacts on the therapists themselves were noted, which included enhancing the supervisee's learning and development, their willingness to disclose to their supervisors and their ability to cope and maintain their wellbeing. There were also a number of studies that highlighted the impact of supervision on therapists' practice. This included what the therapist explored in the therapy session and how they felt towards their relationship with their client. Finally, there was some evidence for direct impacts of supervision on clients, although the findings were mixed and, therefore, inconclusive.

The review highlighted a number of methodological issues that are consistent with those found by Wheeler and Richards (2007), that is, studies tended to include limited information regarding the characteristics of supervisees, supervisors and clients that they included in the study. The studies were also generally unclear about the type of supervision or the supervision activities that were being evaluated. A lack of theory-driven research was also noted. Apart from research that explored specific, novel models of supervision, studies generally did not describe the theory behind the supervision being explored. Therefore, contextual factors were not sufficient to give the reader a clear enough sense of who was doing what and why, which limits the practical usefulness of the findings. This is a shame as studies offer an insight into the creative ways in which supervision is conducted and how the developmental needs of the supervisee are being approached. This highlights the supervision literature to be rich and exciting in its development and it would be valuable for the experiences of others to be more easily applicable to currently practising clinicians.

Wheeler and Richards (2007) called for the use of qualitative studies in the investigation of supervision, which is reflected in the findings of this review with nearly half of the studies adopting qualitative approaches. Given the complexity and evolving nature of the process of supervision, qualitative approaches potentially offer a richer and more detailed account of the processes involved and may be more useful for clinicians seeking to develop their supervision practice. In order to be clear about the impact of supervision a quantitative study would ideally include a control group where supervision was not provided. However, as Falender (2014) points out, the ethical challenges posed by not providing supervision makes this impossible. Perhaps in the absence of rigorous quantitative approaches qualitative methods are more appropriate for this area of exploration. This was reflected in the review as qualitative approaches tended to receive higher ratings on the QAC.

Consistently with Wheeler and Richards' (2007) findings, studies continue to utilise trainee therapists to explore the impact of supervision. While trainee experiences of supervision are important, it cannot be assumed that the findings from trainee studies are generalisable to qualified therapists. In addition, trainees have the added component of evaluation that may alter the supervisor relationship. It is also possible that there are significant differences between early or brief supervision relationships and those that are well-established and enduring. However, this was not explored in any of the studies included in the review. Given that supervision is mandated throughout the career of a therapist it is important that the impact of supervision on therapists at various points in the career is accounted for.

The results of the review ultimately highlight the complexity of exploring the processes involved in supervision and how supervision impacts on the various parties it aims to serve. It is clear that the process, and resulting outcomes, of

supervision are ever evolving. As the studies in the review have shown, the style and content of supervision appears to impact on the way in which the supervisee experiences subsequent supervision sessions. This creates an inevitable challenge when attempting to explore how supervision impacts or influences those involved. This brings in to question whether attempting to take a snapshot of supervision and assessing the subsequent short-term impact is a valid method of exploring the value of supervision. Despite Wheeler and Richards' (2007) recommendations, there continues to be a lack of studies exploring the longitudinal impacts of supervision. Ideally, studies would aim to explore the impacts of supervision throughout training or over longer periods of time.

Recommendations

In order to answer the question of how supervision impacts on therapists, their practice and their clients, there is a need to develop a clearer sense of what supervision is for. Milne's (2007) definition has facilitated this but, to date, there is little evidence that studies are using the definition as a basis for their research. The next step is to take this definition and use it to systematically explore how effective supervision actually is. A clear research agenda would provide direction and clarity about the goals for supervision research, allowing consistency and replication of findings. While there is a wealth of information about the various impacts of supervision, the disparity between the different studies and the different therapists involved makes it challenging to develop a cohesive picture of the impact of supervision.

Finally, it is essential that any research conducted into the impact of supervision hold the clinical implications of the study at its core. After all, in order

for the literature to develop supervision practices, the findings must be easily translatable to the 'real world' of the therapist and client.

Conclusion

Falender (2014) suggests that supervision has become something that is valued and expected without sufficient evidence to justify this. However, despite the lack of clear evidence for supervision, professionals appear to continue to value and benefit from engaging in the process. Perhaps this suggests that it is time to consider the wider values of supervision in order to establish its place in the modern health system. Many of the studies in this review did not explore client outcome which may reflect a belief amongst professionals that client outcome is not the only way of measuring supervision outcome. After all, it is questionable whether many therapists would consider supervision to have failed simply because the client shows no sign of improvement.

That being said, there is no doubt of the importance of clients in the work of psychological therapists. As the recent Francis Report (The Mid Staffordshire NHS Foundation Trust, 2013) states:

The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights. (p. 85)

The report clearly emphasises the need for caring and compassionate staff in order to facilitate a safe and effective service for clients. However, in order to ensure that these values are upheld it is imperative that there is some consideration to the ways in which staff, including psychological therapists, can be supported to allow them to thrive in their therapeutic work. By considering, and evaluating, the *normative, formative* and *restorative* components of supervision that Milne (2007) highlights, we may be better placed to ensure that clients receive the best service possible while maintaining the wellbeing and development potential of psychological therapists.

References

- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: text revision* (4th ed.). Arlington, VA: American Psychiatric Association.
- Ancis, J. R. and Landany, N. (2001). A multicultural framework for counseling supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process and practice* (3rd ed., pp. 63-90). Philadelphia, PA: Brunner-Routledge.
- Ancis, J. R., & Marshall, D. S. (2010). Using a multicultural framework to assess supervisees' perceptions of culturally competent supervision. *Journal of Counseling & Development*, 88(3), 277-284.
doi:<http://dx.doi.org/10.1002/j.1556-6678.2010.tb00023.x>
- Anderson, T., Crowley, M. E., Patterson, C. L., & Heckman, B. D. (2012). The influence of supervision on manual adherence and therapeutic processes. *Journal of Clinical Psychology*, 68(9), 972-988.
doi:<http://dx.doi.org/10.1002/jclp.21879>
- Andersson, L., King, R., & Lalande, L. (2010). Dialogical mindfulness in supervision role-play. *Counselling & Psychotherapy Research*, 10(4), 287-294. doi:<http://dx.doi.org/10.1080/14733141003599500>
- Beinart, H. (2004). Models of supervision and the supervisory relationship and their evidence base. In I. Fleming and I. Steen (Eds.), *Supervision and clinical psychology* (pp. 36-50). Hove: Brunner-Routledge.
- Bernard, J. M. (1997). The discrimination model. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp.310-327). Chichester: John Wiley & Sons.

- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision*. London: Pearson.
- Bordin, E. S. (1983). A working alliance based model of supervision. *The Counseling Psychologist*, 11(1), 35-42.
- British Association for Counselling and Psychotherapy (BACP). (2013). *Framework for Good Practice in Counselling & Psychotherapy*. Lutterworth, Leicestershire: British Association for Counselling and Psychotherapy. Retrieved April 13, 2015, from www.bacp.co.uk
- British Psychological Society: Division of Clinical Psychology. (2014). *DCP Policy on Supervision*. Leicester: The British Psychological Society. Retrieved April 13, 2015, from www.shop.bps.org.uk
- Butler, S. F., Henry, W. P., & Strupp, H. H. (1995). Measuring adherence in time-limited dynamic psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 32(4), 629-638. doi:<http://dx.doi.org/10.1037/0033-3204.32.4.629>
- Caldwell, K., Henshaw, L., & Taylor, G. (2005). Developing a framework for critiquing health research. *Journal of Health, Social and Environmental Issues*, 6(1), 45-54.
- Critical Appraisal Skills Programme (CASP)*. (2013). Qualitative Research Checklist. Retrieved December 12, 2014, from <http://www.casp-uk.net>
- Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of healthcare interventions. *Journal of Epidemiological Community Health*, 52, 377-384.

- Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, 37(3), 322-329. doi:<http://dx.doi.org/10.1037/0022-0167.37.3.322>
- Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp.447-507). Chichester: John Wiley & Sons.
- Eriksen, K. P., & McAuliffe, G. J. (2003). The counseling skills scale: A measure of counselor competence. *Counselor Education and Supervision*, 43, 120–133.
- Falender, C. A. (2014). Supervision outcomes: Beginning the journey beyond the emperor's new clothes. *Training and Education in Professional Psychology*, 8(3), 143-148. doi:<http://dx.doi.org/10.1037/tep0000066>
- Friedlander, M. L., & Ward, L. G. (1984). Development and validation of the Supervisory Styles Inventory. *Journal of Counseling Psychology*, 4, 541-557.
- Grossl, A. B., Reese, R. J., Norsworthy, L. A., & Hopkins, N. B. (2014). Client feedback data in supervision: Effects on supervision and outcome. *Training and Education in Professional Psychology*, 8(3), 182-188. doi:<http://dx.doi.org/10.1037/tep0000025>
- Hawkins, P., & Shohet, R. (2006). *Supervision in the helping professions* (3rd ed.). Maidenhead: Open University Press.
- Hess, S. A., Knox, S., Schultz, J. M., Hill, C. E., Sloan, L., Brandt, S., . . . Hoffman, M. A. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Research*, 18(4), 400-411. doi:<http://dx.doi.org/10.1080/10503300701697505>

- Holloway, E. L. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage.
- Knox, S., Burkard, A. W., Edwards, L. M., Smith, J. J., & Schlosser, L. Z. (2008). Supervisors' reports of the effects of supervisor self-disclosure on supervisees. *Psychotherapy Research*, 18(5), 543-559.
doi:<http://dx.doi.org/10.1080/10503300801982781>
- Kolden, G. G. (1996). Change in early sessions of dynamic therapy: Universal processes and the generic model of psychotherapy. *Journal of Consulting and Clinical Psychology*, 64(3), 489-496. doi:<http://dx.doi.org/10.1037/0022-006X.64.3.489>
- Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology*, 43, 10-24.
doi:[10.1037/0022-0167.43.1.10](http://dx.doi.org/10.1037/0022-0167.43.1.10)
- Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okishi, J., Burlingame, G. M., & Reisinger, C. W. (1996). *Administration and scoring manual for the OQ-45.2*. Salt Lake City, UT: American Professional Credentialing Services.
- Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology*, 39(1), 105-120.
doi:<http://dx.doi.org/10.1037/0022-0167.39.1.105>
- Lenz, A. S., Sangganjanavanich, V. F., Balkin, R. S., Oliver, M., & Smith, R. L. (2012). Wellness model of supervision: A comparative analysis. *Counselor Education and Supervision*, 51(3), 207-221.
doi:<http://dx.doi.org/10.1002/j.1556-6978.2012.00015.x>

- Mcaleavey, A. A., Castonguay, L. G., & Xiao, H. (2014). Therapist orientation, supervisor match, and therapeutic interventions: Implications for session quality in a psychotherapy training PRN. *Counselling & Psychotherapy Research, 14*(3), 192-200.
doi:<http://dx.doi.org/10.1080/14733145.2014.929418>
- McCarthy, K. S., & Barber, J. P. (2009). The multitheoretical list of therapeutic interventions (MULTI): Initial report. *Psychotherapy Research, 19*(1), 96–113. doi:10.1080/10503300802524343
- Miller, S. D., & Duncan, B. L. (2000). *The Outcome Rating Scale*. Chicago, IL: Author.
- Miller, S. D., Duncan, B. L., & Johnson, L. D. (2000). *The Session Rating Scale 3.0*. Chicago, IL: Author.
- Milne, D. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology, 46*, 437-447.
- Myers, J. E. & Sweeney, T. J. (2004). *Manual for the five factor wellness inventory*. Palo Alto, CA: Mind Garden.
- O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The vanderbilt psychotherapy process scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology, 51*(4), 581-586.
doi:<http://dx.doi.org/10.1037/0022-006X.51.4.581>
- Orlinsky, D. E., Gerin, P., Davis, J., Davis, M., Ambuhl, H., Willutzski, U., ... Iahns, J.F. (1991). *The international study of the development of psychotherapists: Conceptual organizational of the common core questionnaires*. Unpublished manuscript, University of Chicago, IL.

- Osipow, S. H. (1998). *Occupational Stress Inventory Revised Edition (OSI-R) professional manual*. Lutz, FL: Psychological Assessment Resources, Inc.
- ProQuest LLC. (2009). RefWorks (Version 2.0) [Computer Software]. Retrieved November 1, 2014, from www.refworks.com
- Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, 3(3), 157-168. doi:<http://dx.doi.org/10.1037/a0015673>
- Sadler, P., Ethier, N., Gunn, G. R., Duong, D., & Woody, E. (2007). Are we on the same wavelength? Interpersonal complementarity as shared cyclical patterns during interaction. *Journal of Personality and Social Psychology*, 97, 1005–1020. doi:10.1037/a0016232
- Spence, N., Fox, J. R., Golding, L., & Daiches, A. (2014). Supervisee self-disclosure: A clinical psychology perspective. *Clinical Psychology & Psychotherapy*, 21(2), 178-192. doi:<http://dx.doi.org/10.1002/cpp.1829>
- Starr, F., Ciclitira, K., Marzano, L., Brunswick, N., & Costa, A. (2013). Comfort and challenge: A thematic analysis of female clinicians' experiences of supervision. *Psychology & Psychotherapy: Theory, Research & Practice*, 86(3), 334-351. doi:<http://dx.doi.org/10.1111/j.2044-8341.2012.02063.x>
- Sterner, W. R. (2009). Influence of the supervisory working alliance on supervisee work satisfaction and work-related stress. *Journal of Mental Health Counseling*, 31(3), 249-263.

- Stoltenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists: A developmental approach*. San Francisco, CA, US: Jossey-Bass, San Francisco, CA.
- Strong, S. R., Hills, H., & Nelson, B. (1988). Interpersonal communication rating scale (rev. ed.). Richmond, VA: Virginia Commonwealth University.
- The Mid Staffordshire NHS Foundation Trust. (2013). *Report of the Mid Staffordshire NHS foundation trust public inquiry: Executive summary*. London: HMSO.
- Tracey, T. J., Bludworth, J., & Glidden-Tracey, C. E. (2012). Are there parallel processes in psychotherapy supervision? an empirical examination. *Psychotherapy: Theory, Research, Practice, Training*, 49(3), 330-343.
doi:<http://dx.doi.org/10.1037/a0026246>
- Wampold, B. E., & Holloway, E. L. (1997). Methodology, design, and evaluation in psychotherapy supervision research. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp.11-30). Chichester: John Wiley & Sons.
- Watkins, C. E., Jr. (2012). Development of the psychotherapy supervisor: Review of and reflections on 30 years of theory and research. *American Journal of Psychotherapy*, 66(1), 45-83.
- Weiss, D. J., Dawis, R. V., England, G. W., & Lofquist, L. H., (1967). *Manual for the Minnesota Satisfaction Questionnaire*. Minneapolis: University of Minnesota.
- Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling & Psychotherapy Research*, 7(1), 54-65.
doi:<http://dx.doi.org/10.1080/14733140601185274>

Worthen, V. E., & Isakson, R. L. (2003, August). Enhancing supervisory relationships (Report No. CG-032 566). Paper presented at the 111th Annual Conference of the American Psychological Association, Toronto, Canada. (ERIC Document Reproduction Service No. ED479919)

Chapter 2: Empirical Paper

Navigating through the decision to have personal therapy during clinical psychology training: An Interpretative Phenomenological Analysis

In preparation for submission to *Clinical Psychology and Psychotherapy* (See
Appendix A for author instructions for submission).

Overall chapter word count (excluding tables, figures and references): 8167

Abstract

Personal therapy has been found to support the personal and professional development of therapists. However, it is not a requirement of clinical psychology training; trainees must decide for themselves whether they wish to have personal therapy. Therapists' motivations to engage in therapy are well documented, as is the experience of having therapy, but little is known about the experience of deciding whether to have it or not. This qualitative study used Interpretative Phenomenological Analysis to explore trainee clinical psychologists' experiences of the decision making process: the experience of deciding whether to have personal therapy during training. Ten trainees from one training course participated in semi-structured interviews. Three main themes were identified from the participants' experiences: *My Self within My World*; *Developing a personal construct of therapy*; and *Fear and hope*. The training context appears to both support and restrict the likelihood of trainees engaging in therapy. Further research might extend the current findings by exploring the experiences of trainees in other training settings. Clinical psychology trainees may benefit from support with developing a personal formulation of their personal therapy needs.

Key Practitioner Messages:

- Trainees engage in a process of exploration in relation to their personal therapy needs.
- Training courses and peers are important in influencing a trainee's decision to have therapy.
- Training course teams could offer trainees support with formulating their own personal therapy needs.

Keywords: Personal therapy, clinical psychology, training, decision

Introduction

Personal and Professional Development in Clinical Psychology

The British Psychological Society (BPS; 2013) highlights the importance of the personal and professional skills and values that are integral to the role of a clinical psychologist. More specifically, the BPS emphasises the value of “developing strategies to handle the emotional and physical impact of own practice and seeking appropriate support when necessary” (BPS, 2013, p. 22). This emphasis on developing skills to manage the personal impact of working in the role of a clinical psychologist has resulted in increased attention being placed on the need for Personal and Professional Development (PPD) during clinical psychology training. PPD focuses on the interface between the person of the psychologist and the professional psychologist (Zhao-O’Brien, 2011).

Youngson and Hughes (2009) proposed a model of personal development for clinical psychologists that describes the process individuals go through in order to decide whether to engage in a particular activity of personal development. The model highlights an individual noticing ‘clues’ that indicate to them that ‘something is not quite right’. If the clue is attended to, internal reflection is undertaken in order to develop a personal understanding of the clue. The extent to which knowledge and understanding of the issue is gained influences whether further action is undertaken. The authors describe a process of revolving around a loop of internal reflection, gaining and losing insight throughout. The individual decides whether to engage in a process of change by making an assessment of the impact of change and whether the consequences of change would be desirable.

It is thought that engaging in PPD allows psychologists, and other members of the helping professions, to increase their self-awareness and resilience, which is required for their professional role (Gillmer & Marckus, 2003). The emphasis on developing resilience during clinical psychology training is undoubtedly important given the considerable psychological distress and additional stress that the training course can create for trainees (Cushway, 1992). These experiences are not uncommon amongst members of the helping professions. For example, psychologists, counsellors and social workers have been found to experience personal distress (including depression, anxiety and marital-distress) within their role and have chosen to engage in personal therapy, a form of personal development, as a result (Bike, Norcross & Schatz, 2009; Daw & Joseph, 2007).

Personal Therapy for Therapists

What personal therapy actually entails is often not specified in the literature, partly because what constitutes personal therapy varies widely depending on the preference and theoretical orientation of the therapist. The value that is placed on personal therapy also varies according to the position of the therapist (Macran & Shapiro, 1998).

Personal therapy has been frequently endorsed by some therapists within the helping professions in order to facilitate PPD (see Norcross, 2005, for a review). The concept of therapists receiving therapy themselves began with Freud (1937) with an emphasis on the need to develop awareness of counter-transference and the complex dynamics within the therapeutic relationship. Therapy is considered to enhance therapist effectiveness and to maintain therapist wellbeing (Macran & Shapiro, 1998). This benefit is achieved by encouraging the therapist to reflect on personal

experience and apply their experiences to their clinical work (Wigg, Cushway & Neal, 2011). One example of this is the experience of personal therapy fostering positive traits within the therapist (e.g. empathy, warmth etc.), which, consequently, has a positive impact on the therapeutic relationship (Marcran & Shapiro, 1998). The supportive nature of personal therapy has also been highlighted (Grimmer & Tribe, 2001).

Qualitative studies exploring therapists' experiences of therapy support these ideas. For example, Kumari (2011) indicated that trainee counselling psychologists found therapy enhanced their therapeutic practice while providing them with opportunities for personal development. Similarly, Rake and Paley's (2009) findings suggest that therapy enhances therapist self-awareness and develops their understanding of themselves. As a result of these findings, it is understandable that personal therapy is frequently a mandatory component of psychological therapy training.

However, it is worth noting that personal therapy during training is not without difficulties. Moller, Timms and Alilovic (2009) found that although clinical psychology and counselling psychology trainees experienced personal therapy as something that helps them to be a better practitioner, they also felt that it 'cost' them. This was both in terms of the negative impact it can have on training and the fear that therapy will expose them to additional distress. This is a consistent finding within the literature. Kumari (2011) found that despite the learning and personal development that counselling psychologists experienced from mandated personal therapy, they also experienced personal therapy as an additional source of stress. Similarly, psychotherapists in Rake and Paley's (2009) study relating to the impact of personal therapy on therapeutic practice highlighted the many detrimental aspects

of personal therapy, including the experience of therapy being destabilising and comments made by their therapists leaving a lasting mark. They also expressed concerns about the unsettling nature of personal therapy having a negative impact on their work with clients.

As a result of these mixed findings, Atkinson (2006) has highlighted the importance of giving psychological therapy trainees the option of having personal therapy, rather than making it a mandatory part of their training. Rather than an emphasis on personal therapy specifically, Atkinson highlights the importance of being provided with “substantial opportunity for personal development in the training of therapists” (Atkinson, 2006, p. 408), which may not necessitate engaging in personal therapy specifically.

Personal Therapy in Clinical Psychology

Clinical psychology training adopts the approach suggested by Atkinson (2006). Therefore, trainees are not generally required to have any form of personal therapy during their training. This approach has been attributed to the adoption of the scientist-practitioner model, which primarily emphasises the use of evidence-based practice (Rake, 2009), rather than a focus on the use of the psychologist as the tool for therapy. Despite this, clinical psychologists have experienced similar benefits from personal therapy to those of other professions, such as counselling psychologists (Moller et al., 2009), and have expressed a wish for personal therapy to be a more integrated part of training (Nel, Pezzolesi & Stott, 2012).

The Decision to have Personal Therapy

As clinical psychology trainees are not required to have therapy as part of their training, they are often required to make the decision for themselves as to whether it would be of benefit. There is limited research exploring the motivations for clinical psychologists to have personal therapy but similar findings are reflected in the therapist research generally.

Digiuni, Jones and Camic (2013) found that clinical psychology students were more likely to have positive attitudes towards seeking therapy if they perceived the faculty staff to view therapy positively. The study highlighted that clinical psychology students' attitudes towards having therapy is significantly affected if they perceive others (including faculty staff and wider society) to have negative attitudes towards having therapy.

Similarly, Dearing, Maddux and Tangney (2005) explored factors that predict whether graduate psychology students engaged in personal therapy. The study highlighted the influence of faculty attitudes, not as a predictor for having therapy, but as a factor that may enhance the student's existing personal views of therapy. Unsurprisingly, students were more likely to participate in therapy if they had favourable attitudes towards therapy and believed that therapy was an integral part of the training process. However, they were put off by the potential financial costs and concerns about confidentiality.

Timms (2010) explored the expectations of personal therapy of trainees on the Bristol clinical psychology training course as part of a wider study that explored clinical and counselling psychology trainees' experiences of personal therapy (Moller et al., 2009). Although, the results of this study were not separately published, Timms outlined the findings of the Bristol study in the Clinical

Psychology Forum. As she describes, trainees were allocated £300 to spend on personal therapy with 98 out of 126 trainees opting to have therapy over seven cohorts of trainees. Trainees had the option to choose at what point during their three-year training course they wished to engage in 10 sessions of individual therapy that had been negotiated by the training course.

Thematic analysis of interviews with trainees highlighted that they anticipated that personal therapy might be able to ameliorate the emotional distress caused by the experience of training. They expected to feel more robust as a result of personal therapy supporting them with their own personal difficulties. Trainees highlighted their understanding of the need to address personal issues in order to prevent the safety of their therapeutic practice being affected.

This is consistent with Daw and Joseph's (2007) findings, which suggest that qualified therapists are most likely to engage in personal therapy for reasons of personal growth or personal distress. However, as the study explored therapy experiences over the lifetime, 59% of the participants also cited personal therapy as a training requirement as a reason for engaging in therapy.

In addition, trainees in Timms' study also expected that personal therapy would enhance their self-development by increasing their self-awareness, their clinical skills and their empathy towards their client through the experience of being a client. The study also highlighted the need for trainees to explore themselves as clients in order to reduce the expert/service-user power dynamic of the therapeutic relationship.

Trainees expressed concerns about what therapy could reveal and the possible negative impact this could have on their training. They described the fear of being exposed as inadequate or unstable.

Rationale for Current Study

There is a wealth of research around experiences of personal therapy in trainee therapists. However, this research focuses on: trainees that are required to have personal therapy as part of their training (e.g. Moller et al., 2009; Daw & Joseph, 2007); the reasons for engaging in therapy (e.g. Bike et al., 2009; Daw & Joseph, 2007; Digiuni et al., 2013); or the expectations that trainees had of therapy and their hopes for the outcomes of the process (Timms, 2010).

There is some evidence relating to what motivates clinical psychology trainees to engage or not engage in personal therapy, but little is known about the experience of deciding whether or not to have personal therapy during training. This is perhaps surprising given the lack of consistency about the use of personal therapy within the profession. Clinical psychology trainees represent a group of individuals that are often engaging in psychological therapy while they train (Holzman, Searight & Hughes, 1996) but do not commonly have their personal therapy experience mandated by the training provider. Therefore, it is likely that trainees on training courses are engaging in a decision-making process.

Qualitative methodologies, specifically Interpretative Phenomenological Analysis (IPA), have successfully explored therapists' experiences of having personal therapy (Kumari, 2011; Rake & Paley, 2009). However, this approach has yet to be adopted to explore experiences of deciding whether to have personal therapy in the first place.

Having a clearer sense of how trainees experience the process of deciding to have personal therapy while training will give future trainees an understanding of how this process can be understood and managed. This understanding may also

facilitate those guiding trainees in their decision e.g. training courses, supervisors, course tutors.

Aims

The current study aimed to adopt an IPA approach to explore the research questions:

1. What are the decision-making processes employed by trainee clinical psychologists during the course of deciding whether or not to have personal therapy during training?
2. How do trainees experience this decision-making process?

Methodology

Research Design

In order to facilitate the exploratory nature of the research question, a qualitative research design was selected. As the study aimed to develop an in-depth understanding of the lived experiences of clinical psychology trainees while they make a decision about having personal therapy, an Interpretive Phenomenological Analysis (IPA) approach was felt to be most appropriate. IPA aims to explore how participants perceive and explain situations that they are experiencing while taking into account the experience and position of the researcher as being an active participant in the research process (Smith, Flowers & Larkin, 2009). Attending to the role of the researcher was particularly important given the experience of the researcher as a training clinical psychologist. Although, IPA was selected as the approach for this study, a discourse analysis methodology (Potter, 2003) would also

have been appropriate. Discourse analysis would facilitate exploration into how trainees make sense of their decision-making processes by exploring their use of language to construct knowledge and meaning of their experiences. However, it was felt that IPA would allow the role of the researcher to be more fully considered while also focusing on the true lived experiences of the participants.

Recruitment

Purposive sampling was used to select small numbers of participants based on their ability to enhance understanding of the research topic (Smith et al., 2009). In order to achieve a homogenous sample (Smith et al., 2009), trainees from only one Doctorate in Clinical Psychology training course were selected to participate. It was felt that this was appropriate given the variety in approaches of the different training courses in the UK. Participants were eligible to participate if they had considered having personal therapy at any time during their training, regardless of whether they had engaged in personal therapy or not. This was considered reasonable as all the participants would likely have had the experience of deciding whether to have personal therapy or not and would be able to offer valuable insight into the research question.

In order to allow for a sufficient sample, two training cohorts were contacted. Eligible participants were invited to participate via an email from the course administrator, which included the Participant Information Sheet (Appendix E). Participants were asked to express their interest via email to the researcher or contact the telephone number on the Participant Information Sheet. In total, 28 trainees were sent the invitation email, 10 of whom expressed an interest in participating.

Participants

Ten trainee clinical psychologists (eight females, two males) took part in the study. One participant was aged 20-24, five were aged 25-29, three were aged 30-34 and one was aged 35-39. At time of interview, five participants were in their first year of training, one was in their second year and four were in their third, and final, year of training. At the time of interview, four participants had not had therapy at all, three had had therapy during their training, one had therapy prior to training and two had therapy both before and after training.

Materials

A semi-structured Interview Schedule (see Appendix F) was developed with consideration of the research aims, current literature, liaison with psychologists involved in the training of clinical psychologists and the supervision team. This method of data collection was selected as it allowed a flexible process to take place in order to tailor the exploration to the individual's experience or interests (Smith & Osborn, 2003), which is key in IPA. Interview questions were designed with the intention of guiding the interview rather than to fully dictate the structure of the interaction (for examples of questions refer to Appendix F).

Care was taken to develop questions that were open, rather than closed, and were not leading (Smith et al., 2009). The schedule aimed to elicit the participant's experiences in terms of factors that may have influenced their decision as well as how they made sense of the decision they were making.

Personal therapy was deliberately not defined by the researcher in the interview schedule as it was felt that it was important to be guided by the

participants' understanding of what personal therapy meant for them, rather than the researcher enforcing their ideas of personal therapy onto the participant.

Procedure

Interview procedure. Interviews took place between August 2014 and October 2014. In order to encourage participants to feel able to talk openly and safely about their experiences, they were invited to choose the location for the interview. Nine of the participants chose to be interviewed in a room at the University in which they studied, one was interviewed at their home.

Prior to the start of the interview, each participant was read a description of the study and given the opportunity to ask any questions (see Appendix G). Following this, they were asked to read, complete and sign a Consent Form (see Appendix H). Demographic information was then collected (see Appendix I). Interviews were audio-taped and lasted between 32 minutes and 53 minutes, with an average of 41 minutes.

Ethical procedure. The study was conducted in accordance with the British Psychological Society's *Code of Human Research Ethics* (BPS, 2010). Prior to commencement of the study, ethical approval was gained from Coventry University Ethics Committee (see Appendix J).

In the interest of maintaining confidentiality, the trainees in the researcher's own cohort were not approached to participate. Participants were informed via the Participant Information Sheet (Appendix E) that they were free to withdraw from the study up to two weeks following their participation in the study.

Following completion of the interview, participants were reminded of support available to them should participating in the study have caused them any

distress (No participants described having been distressed as a result of participating).

Analysis

Following completion of the interviews, the audio-recordings were transcribed verbatim. Identifying information was removed and participants were assigned a pseudonym. Analysis of the transcripts was conducted according to the principles of IPA (Smith et al., 2009; see Appendix K for a summary of the analysis process). An example of one participant's coded transcript (Appendix L) and the corresponding emergent themes (Appendix M) can be found in the appendices.

Validity of the study. Initial coding of one transcript was verified by an independent researcher who was not known to the participants and any discrepancies were discussed and resolved. Ongoing supervision from the research team was provided relating to reading transcripts, initial noting, emergent themes and final themes with consideration of the researcher's position and how this may influence their analysis and interpretation.

The researcher's position. The hermeneutic theoretical underpinning of IPA highlights the importance of the researcher's involvement in understanding and making sense of how a phenomenon appears (Smith et al., 2009).

The researcher was a White-British, female trainee clinical psychologist currently training on the course that was selected to participate. She engaged in private personal therapy during her training. A bracketing interview was conducted to identify and make explicit the researcher's own experiences, beliefs and assumptions (Smith et al., 2009). Prior to conducting the research, the researcher's beliefs centred around the idea that therapy may be of benefit to training clinical

psychologists, both for personal and professional reasons, but that the decision about whether to engage in personal therapy should lie with the trainee themselves. Care was taken to ensure that these assumptions and beliefs were held in mind throughout data collection and analysis and supervision was used to facilitate this.

Results

This study explored the experiences of trainee clinical psychologists during the course of deciding whether or not to have personal therapy during training. As a result of the analysis, three main themes emerged: *My Self within My World*, *Developing a personal construct of therapy* and *Fear and hope* (Table 2.1). Each main theme with the corresponding sub-themes will now be described in more detail.

Table 2.1

Main Themes and Sub-themes Resulting from the IPA Analysis

Main themes	Sub-themes
Theme 1: My Self within My World	Breaking boundaries Am I as good as the others? Losing my bearings Being surrounded
Theme 2: Developing a personal construct of therapy	Where's the problem? What's normal?
Theme 3: Fear and hope	Fear of therapy Hope and faith

Theme 1: My Self within My World

All of the participants described exploring themselves within the context of their external environment and how this experience impacted on their decision to have personal therapy. This theme is discussed under the sub-themes of *Breaking boundaries*, *Am I as good as the others?*, *Losing my bearings* and *Being surrounded*.

Breaking boundaries

Participants highlighted an awareness of the boundaries between themselves and aspects of their training and they described the challenges of maintaining these boundaries. Michael expressed his fears about the lines between professional and personal life becoming blurred. He described boundaries acting as a form of protection for his personal self:

When you're on placement, it's quite obviously something professional but then...teaching days cos, I think that everybody in our year gets on quite well then it feels a bit more blurred. Are they colleagues? Are they friends?...that...contributes to the...lines getting blurred and...how to put boundaries in to...protect personal time so everything's not...spilling out.

(Michael, 89-95)

In addition, participants described concerns about therapy breaking boundaries and blurring the lines between themselves and their professional lives. For example, Mark expressed his apprehension about therapy impacting on his personal life and relationships:

I value that time and just...being normal, being a human being, being somebody who's...not a psychologist. So, I guess, I've only got so much time and energy and ...the negative consequence (of therapy) I thought was...it's adding something else in. It's impinging on my ability to do...other things.

(Mark, 308-313)

Later, Mark highlighted the fluidity of boundaries by indicating the arbitrary nature of the personal-professional boundary, which was a common sense amongst the participants:

I mean it's called personal and professional like it's separate...but I do think the two things are...really the same thing.

(Mark, 98-100)

Laura expressed her concerns about the emotional boundaries that could be broken as a result of engaging in therapy. She described her fears about her emotions escaping from the therapy environment and impacting on the rest of her life if therapy did not feel safe:

It (therapy) could be very messy in that if I don't feel contained I'm going to have emotions spilling out all over the place which would impact on life as a whole.

(Laura, 414-415)

Contrastingly, Amy described her concerns about her personal difficulties interfering with her professional life and the role that therapy may be able to play in preventing this:

So if I was having therapy to build my confidence or whatever it might have looked like, then...I...would be dealing with it and...it wouldn't have to figure in my work life.

(Amy, 87-89)

Am I as good as the others?

Participants were also inclined to note an awareness of themselves in relation to others in their environment, often in the form of a negative comparison. The participants appeared to experience the environment of training as eliciting a culture of comparison. Clare described the comparisons she makes between herself and others and the desire to be at a similar level to those around her:

Maybe, that's the nature of many people that come into psychology but...I feel that I...compare myself with other people or...what I do. I want to be at least as good as everybody else.

(Clare, 24-26)

Similarly, Caroline commented on the comparisons she makes between herself and others but she also highlighted her assumption that course staff are naturally comparing trainees:

Mostly for me it's the...comparison that...I'll make myself and the...pressure that I put on myself but also just being aware that we are starting and doing the same job together and...supervisors and the course team can't help but...even if it's unconscious, can't help but compare us to each other and to the years that have come before and the years that come after.

(Caroline, 401-406)

Comparisons with others commonly appeared to contribute to feelings of inadequacy in the participants and led to a desire to explore what those feelings towards themselves were about:

At that stage I was thinking about some of the feelings I had about myself...not being good enough was one that was activated at the time...and then starting to explore...where that's come from.

(Laura, 83-87)

There was a definite sense amongst some of the participants that they needed to be different and that therapy would provide a way of achieving this change:

I guess I thought about...possibly needing to be fixed in some way that something wasn't right with what I was doing so I needed help to do things differently, maybe...that there was something wrong in what I was doing.

(Amy, 59-62)

There was a feeling among some participants that their inadequacy could be counteracted by the superiority of a therapist. Rachel described the difficulties she had experienced when trying to manage her struggles on her own and the potential benefits of having someone else available to support the process:

I felt that it would be more constructive with somebody else because...there was a time...before, long before, I started therapy really where...there'd be so much trying to understand what's going on for myself, but when you're just doing that on your own...in my experience...it's not always a very...helpful...place to be...it's good to have somebody else to share that with.

(Rachel, 571-577)

Losing my bearings

Many of the participants described their experience of the training environment as overwhelming, particularly the transient and unsettling nature of training. For example, Laura described the challenges of moving placement every six months:

What is hard on placement is obviously you go in and you have to...settle in with a new team...start running...and then...you're pulled out...six months later when...you're settled and...want to stay there...so that change is quite hard.

(Laura, 42-45)

This feeling of being unsettled appeared to put some participants off engaging in therapy. Ruth expressed doubts about being able to fit therapy in around all the other changes she was experiencing:

Am I gonna have time with all the logistics of getting around to different places, being in different places on placement, and another placement ends and you don't know where you're gonna go next?

(Ruth, 34-36)

Similarly, Caroline described the need to feel more settled with the course before starting therapy for a second time:

I wanted to just...get my bearings, get my feet...settle in with all aspects of the course as much as I could and then think about it (therapy).

(Caroline, 94-96)

In contrast, some of the participants felt that the unsettling nature of the training environment acted as a prompt to engage in therapy. For example, Rachel described making the most of the opportunity of feeling emotionally unsettled:

The course opened up a lot of things anyway...and it just felt like it was a good time to...just embrace that...and work with it...just making the most of the fact that that was all happening anyway.

(Rachel, 563-566)

Being surrounded

The final experience that the participants described in relation to the exploration of themselves in their world was that of being surrounded by ideas about personal therapy. Rachel described her experiences on placement and the 'vibe' of therapy that was around:

They used to talk a lot about the...benefits of therapy...and...I was working with a third year trainee and he was having therapy. So, there was a...vibe going on there that it was the thing to do.

(Rachel, 85-88)

Laura described her experience of a supervisor raising the idea of therapy and developing her beliefs about its value:

She...quite openly raised therapy...quite forcibly actually, it was quite interesting. She's very full-on, direct...psychodynamic...and she...after discussing that, put on this...belief... 'if you don't engage in therapy, you're not going to be a good therapist'.

(Laura, 208-211)

Clare and Beth described their experiences of the training course team opening up the possibility of having therapy and the impact this had on their willingness to consider it:

At the beginning of training...the university was always very open, so not...encouraging you to have therapy but...people were always very open

about that's a choice...if you want to do it...and I think that probably made me feel more...open about it as well.

(Clare, 54-58)

It (therapy) is talked about obviously quite openly at the beginning of the course and...how to access...therapists...which I guess you probably...you don't get...before you start the course...well I didn't anyway.

(Beth, 330-336)

Theme 2: Developing a Personal Construct of Therapy

The second main theme that emerged was related to the participants' development of a personal sense of what therapy is and how therapy relates to them. This theme is described by the sub-themes '*Where's the problem?*' and '*What's normal?*'

Where's the problem?

Participants appeared to develop a sense of what therapy is by wondering what the problem was that therapy needed to solve. Many of the participants explored the necessity of identifying a specific problem in order to engage in therapy, including Mark:

I feel like there should be a reason for it. That's how I would deal with my clients...they come with an issue. They come with something they want to think about...I wouldn't want to do it just for the sake of doing it.

(Mark, 141-146)

However, in contrast, Rachel decided to have therapy despite her concerns about not having a specific difficulty to focus on:

It was weird...not to have *a problem*...so to speak...I probably mentioned that loads...you know, 'there's nothing wrong'...cos there wasn't anything wrong with me (laughs)...I wasn't going cos I had a problem or an issue or...well...probably had several issues, but not like, so it was weird.

(Rachel, 467-473)

Despite the absence of a problem, Rachel was able to explain why she wanted to have therapy:

There are some things that I could do with changing...it was less about...feeling like I couldn't cope and I needed a therapist. It was, I felt like I could cope actually and that I wanted...to...explore some things...to find out about myself.

(Rachel, 315-319)

Participants also disagreed about whether therapy is designed to support them or their professional work. For example, Amy appeared clear about her personal motives for therapy:

I want to be a better psychologist but I feel...I've got to be a better *me* before I can be a better psychologist.

(Amy, 358-359)

In contrast, Michael was clear about personal therapy fitting within the context of his professional development rather than being for personal reasons:

It would have felt like going for personal therapy was part of my work, part of my job as a trainee psychologist rather than...something for me as an individual.

(Michael, 636-638)

What's normal?

As participants appeared to develop an idea of what therapy is, they also seemed to gather a sense of whether therapy is an acceptable thing for them to do. Amy talked about the stigma of health professionals engaging in their own therapy:

That there is this sense that...as a health professional, you're not supposed to need your own help...and I think that still is quite deep-seated in people.

(Amy, 375-377)

Consistently with a number of participants, Amy described a need to have permission or an excuse to have therapy:

(Opting for a specific type of placement) gave me the permission I needed...to undertake the therapy that I'd probably wanted for a while.

(Amy, 150-151)

There was a sense that having therapy needed to be normalised in order for it to be considered as acceptable by the trainees. Clare captured this as she described her experiences of hearing her peer's experiences of therapy:

Another trainee that...I used to see quite a lot and they were really open about...wanting to do therapy as well. So I think again I probably feel that it normalised it.

(Clare, 276-278)

The participants appeared to consider there to be a difference between people that have therapy and those that do not. The difference between how the participants see themselves in relation to being a client was identified:

It's quite a...middle class thing to do. Like, go for therapy. I don't know if middle class or...but...something about who goes for therapy and is that really people like me?

(Rachel, 274-276)

Theme 3: Fear and Hope

The final theme identified was that of Fear and hope, which is described by the sub-themes *Fear of therapy* and *Hope and faith*.

Fear of Therapy

Whether or not participants chose to engage in therapy, all expressed concerns about possible negative outcomes of therapy. Mark was worried about the new ideas that may come up as a result of therapy and the potential for them to overwhelm other areas of his life:

It's going to raise issues...it would be pointless doing it if it didn't raise things...or bring things up for you that you had perhaps not considered or that...you've not considered in that depth. So...a negative aspect could be that...these things would occupy your mind or you'd find yourself thinking about them outside.

(Mark, 328-335)

Laura described having concerns about the changes that might result from therapy, particularly for her personal relationships:

What if I suddenly realise something and then...I don't want to be with my partner any more...I've heard that therapy can change...people and...how you view things...and that's scary as well.

(Laura, 346-351)

Michael described a feeling of struggling to move forward with his decision as a result of his fears about therapy:

I was a bit stuck because I didn't really want to go and do something psychodynamic because I thought it was a bit scary...I thought if I wanted to go with not much of a reason then that would be somewhere to go cos it could be quite exploratory. Well, I knew other people who'd gone for it and it just felt like it would be quite scary and quite destabilising.

(Michael, 171-177)

Laura described managing the conflicting ideas she has about the positive and negative aspects of therapy:

I mean, part of me wants to try it cos I'm curious, because I think it will be a really interesting experience and...has the potential of being a very rewarding experience and I think I can learn a lot about...how therapy is from a client's perspective...which I think will be helpful...but then...it's balancing that off against fears...of what would happen if I did go in therapy.

(Laura, 380-385)

In contrast, Lucy expressed fears about the possible consequences of not engaging in therapy:

You've got a supervisor who can help and guide you, you're still the person in that room with that client and whatever you bring...to the therapy process you bring (laughs) and if you haven't got a bit of a handle on it then it can be pretty damaging potentially I guess.

(Lucy, 125-128)

Hope and faith

Many of the participants had ideas about what they would hope, or anticipate, to get out of therapy. Participants were hopeful that they would learn about themselves, including Ruth who described her hopes for increased awareness:

I thought it would be...a better understanding of myself and my current and previous relationships... ..a bit more awareness of the way I see things, the way I think about things.

(Ruth, 159-163)

While Clare described the importance of therapy resulting in changes to the way she reacts to her environment:

What I wanted from therapy was understanding more about...what is it triggering in me that...is causing that strong reaction. But also with...the aim that eventually I will start doing things differently.

(Clare, 158-160)

In contrast, Beth described her hopes for therapy in terms of improving her ability to work therapeutically with her clients:

I...want to feel like I do understand...why I feel certain ways in certain situations and...cause...when you're doing therapy yourself you...need to know what makes you feel certain ways...to...help support the other person to...support the therapeutic process with other people.

(Beth, 233-237)

Participants also captured a sense of belief in the process of therapy regardless of whether they had a specific sense of what the benefits may be. Lucy described her observations of her client work as building her faith in therapy:

All the different types of therapy there are and...seeing how they benefitted people that I'd worked with...a real...belief in the process...of therapy.

(Lucy, 309-311)

Discussion

This study aimed to explore the experiences of clinical psychology trainees deciding whether to engage in personal therapy during their training. Three main themes emerged from the interpretative phenomenological analysis of the interviews and these will now be discussed further. Methodological considerations, areas for further research and clinical implications of the findings will then be considered.

Discussion of the Findings

The language used by the trainees in the study was reflective of an exploratory experience, much like that of a voyage on a ship. Trainees commonly expressed their experiences using phrases such as 'take on board', 'finding your feet', 'comes in waves' and 'a journey'. Navigating the decision to have personal therapy as a trainee clinical psychologist appears to be a complex and conflicting process and the sense of needing to balance the complexities involved was

expressed. The themes that emerged from the trainees' experiences and how the themes relate to each other are represented in Figure 2.1.

The theme *My Self within My World* encapsulated the trainees' awareness of themselves in relation to their surroundings. The trainees expressed a sense of instability and uncertainty as they experienced the unfamiliar world of training. They described being surrounded by new ideas and experiencing constant change. Boundaries that had previously been sustained appeared to have been broken by the training experience and trainees began to question themselves and their abilities.

The breaking of boundaries appeared to increase some trainees' feelings of vulnerability, which suggests that boundaries act as a protective barrier for the self. For some, therapy was seen as a threat to existing barriers and, therefore, a threat to the self.

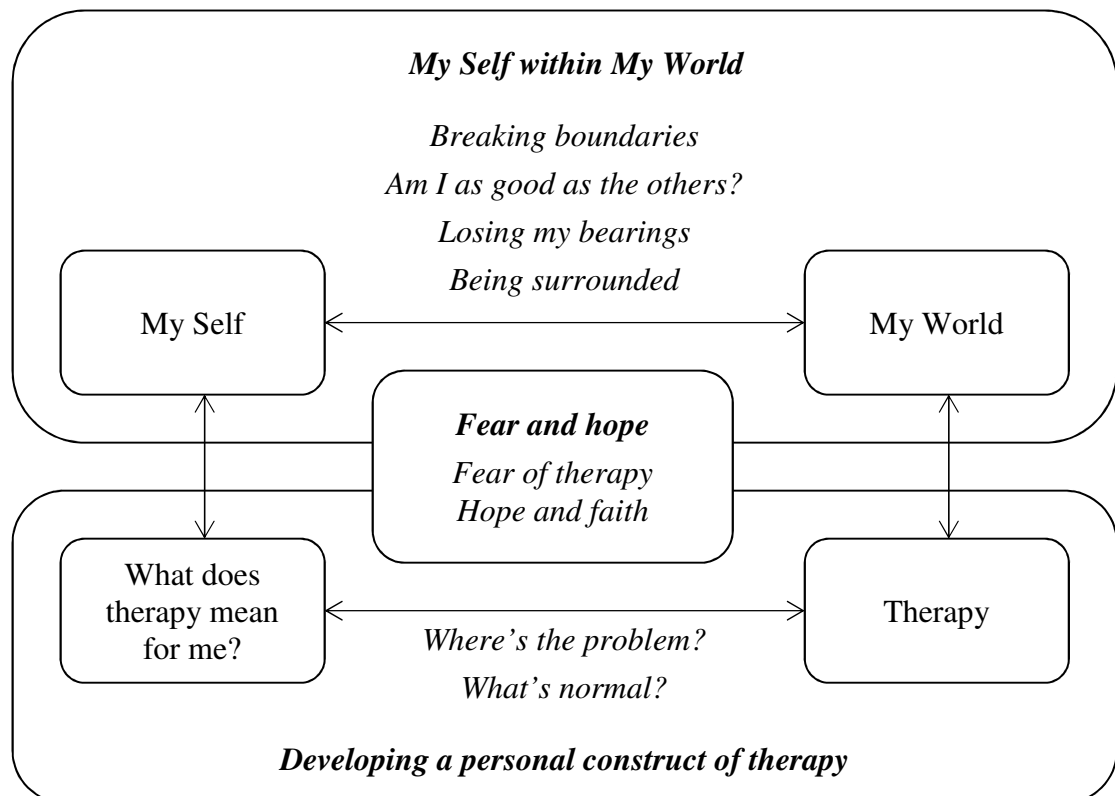


Figure 2.1. The experience of deciding to have personal therapy as a clinical psychology trainee.

Trainees also explored the boundary between themselves and ‘clients’. While they appeared comfortable considering that some people in their world may have therapy, it seemed more challenging to consider therapy for themselves. This shows the disparity between the trainees’ ideas about therapy generally and what therapy means for them specifically. This need to consider the barrier between client and therapist was also highlighted by the trainees in Timms’ (2010) study. However, there was disparity amongst the trainees in the current study as to whether these boundaries actually exist in reality.

Having had the experience of a new world and being exposed to ideas about therapy, trainees began *Developing a personal construct of therapy*. Some felt encouraged to steer towards the idea of having therapy as if sailing into an emerging storm, while others appeared to feel that therapy would be one demand too many and opted to paddle towards calmer waters. This contrasting response may be accounted for by the inevitable individual differences that are apparent between trainees, including availability of personal resources, knowledge of therapy, financial resources and conflicting demands (Youngson & Hughes, 2009).

For some trainees, the culture of training appeared to normalise the process of having therapy and provided them with an ‘excuse’. Trainees described being in a world that was filled with ideas of therapy, with supervisors, course staff and peers bringing ideas of therapy onto their horizons. However, other trainees felt that a culture within clinical psychology raised doubts about whether therapy is appropriate or necessary for professionals. This highlights the importance of the training culture and social stigma on the decision to have therapy as a therapist, which has been consistently described in the literature (Dearing et al., 2005; Digiuni et al., 2013).

Trainees' experiences of training and their ideas about therapy informed their sense of *Fear and hope*. Some were worried about the impact therapy could have on other areas of their lives, again highlighting their awareness of the fragility of the boundaries within their world. There was also a fear that, on top of the overwhelming feelings associated with the training experience, therapy would simply make them feel worse. This fear is unsurprising given therapists' previous experiences of therapy as destabilising (Kumari, 2011).

Some trainees felt confused about the requirement to have a specific reason to have therapy. There was a sense amongst these trainees that there was a desire for a clearly mapped-out route. These trainees appeared to use more cognitive methods of calculating whether therapy was required based on needs, outcomes and evidence. However, others appeared to think that therapy was a process of exploration, blindly sailing into uncharted water without a clear idea of what would be found but being driven by the faith that it will make a change for the better.

For some, this change would come as a result of a better understanding of themselves. This is in keeping with literature which found that need for self-understanding was one of the motivators for psychotherapists seeking personal therapy (Bike et al., 2009) and has been reported as an outcome of personal therapy for trainee counselling psychologists (Kumari, 2011).

Trainees highlighted their understanding of the importance of the relationship with the therapist in therapy. Concurrently, all those that considered having personal therapy only considered therapy approaches that tend to focus on more relational aspects. Participants anticipated that another person would be able to provide them with expertise that they did not have, as well as allow them to see themselves in a new light. This idea of needing someone else fits with the trainees' sense of being

inadequate and perhaps represents a lack of faith in themselves to navigate their journey on their own.

The value of the relationship in therapy has been frequently reported in the existing literature. For example, Ciclitira, Starr, Marzano, Brunswick and Costa (2012) found that volunteer counsellors particularly valued the relational aspects of their personal therapy, both in relation to the therapeutic process and the opportunity for learning theory and skills.

Trainees appear to navigate an ongoing personal battle as part of the decision-making process. The trainees described feelings of being stuck as they attempted to assimilate all the ideas and concepts available to them, which is indicated by the cyclical nature of the model (Figure 2.1). Trainees expressed a need to be more settled in order to manage the experience of therapy. They appeared to fear that therapy would rock the boat, resulting in them losing themselves further but, conversely, that therapy could also put them on the right path to finding themselves.

The findings from this study further inform the model of personal development proposed by Youngson and Hughes (2009). The participants in the study appeared to attend to 'clues' that something was not right, which included feelings of anxiety relating to an experience of being unsettled within their environment or feelings of inadequacy in relation to others. As they considered the reasons why they were having difficulties, the participants appeared to undergo the process of internal reflection that Youngson and Hughes describe. Based on their understanding of therapy, the participants developed an understanding of their problems and what therapy means for them, which allowed them to weigh up the likely consequences of engaging in therapy and whether it would be worth it.

This model sheds some light on why some of the participants in the study felt stuck in their decision-making process. It may be that some participants got stuck in the ‘loop’ of internal reflection, which Youngson and Hughes described, whereby they struggle to develop a clear enough understanding of their difficulties and the ways in which therapy may be able to help them. Alternatively, it may be that they have developed a comprehensive idea of what therapy would be like and feel that the consequences would not outweigh the potential benefits. What is clear from the trainees in this study is that, even if the decision to engage in therapy is made, the process does not end. The hope of change and the belief in therapy as a format for change seems to stick with some trainees while they manage their fears and apprehensions.

Methodological Considerations

In line with the idiographic approach of IPA, the findings of this study are not intended to be generalisable to the wider population of clinical psychology trainees. It is possible that the two cohorts from which the participants were recruited represent a unique sample. Therefore, the findings should be interpreted accordingly.

Similarly, given that the definition of personal therapy was unique to each participant their ideas about personal therapy may not be consistent with ideas of other trainees. However, it is likely that many trainees will be able to relate to the processes of deciding whether to have personal therapy that are described.

Trainees were only eligible to participate in the study if they had considered personal therapy at some point in their training. It was felt that, given the reflective nature of the training course that, this criterion was unlikely to limit the potential participants. However, it is possible that this requirement may have discouraged

some trainees from participating, for example, if they had disregarded personal therapy without much consideration.

Trainees at various points in their training were included in the study. While this could have reduced the homogeneity of the population, it did not appear that stage of training was associated with whether the trainee had engaged in therapy or not.

As Berger (2015) highlights, the position of the researcher as a trainee clinical psychologist may have impacted on the participants' willingness to disclose information during the interviews. The researcher may also have influenced the likelihood that participants would fail to share information that they consider to be obvious. Alternatively, the researcher's understanding of the participants' experiences may have been skewed by her own experiences.

Areas for Future Research

This study has begun to shed some light on trainee clinical psychologists' experiences of deciding whether to have personal therapy during training. Further work could extend this by exploring experiences at various time points during training. It would also be valuable to revisit participants at different points in training to explore whether ideas about deciding to have personal therapy change throughout the training experience. Equally, exploring expectations of therapy in relation to actual therapy experiences would give a broader understanding of the full process of having personal therapy.

Clinical Implications

The trainees in the study described a lack of consistency about attitudes towards personal therapy in clinical psychology. However, as Digiuni et al. (2013) state, the personal nature of the decision to have therapy may make it challenging for any one idea about therapy to be helpful. Concurrently, the trainees in the present study highlighted the importance of the personal choice, particularly relating to the timing of therapy, which suggests that making therapy mandatory for training clinical psychologists would not be beneficial.

Participants appeared to value being given a gentle awareness of the option of personal therapy, as this awareness was not always something that they had experienced prior to their training. Therefore, training courses could offer specific teaching relating to the rationale for and against personal therapy and encourage trainees to explore what is already known about therapists' experiences of therapy. This may further facilitate the information-gathering process that the trainees in the study described.

Given the complexity of the journey of deciding whether to have personal therapy during training, clinical psychology trainees may benefit from support to formulate their personal and professional requirements for therapy. It may be beneficial for trainees to engage in a formal reflective process of exploring the potential role of therapy within the context of their world and consider the hopes and fears that may be influencing their decision. Engaging in this process, perhaps alongside a personal development tutor, may support trainees who feel 'stuck' by the cyclical nature of the decision making process and may facilitate those that lack faith in the value of therapy that others appear to hold.

Conclusion

Trainee clinical psychologists appear to navigate through the decision to have personal therapy during training by exploring whether they have a problem and then considering the extent to which therapy may be an appropriate solution to their problem. The training context appears to both support and restrict the likelihood of trainees engaging in therapy. Additionally, anticipated outcomes of having therapy both motivate and discourage trainees. Some are left feeling stuck in a process of reflection, continually weighing up the advantages and disadvantages of therapy, while those that choose to have therapy appear to rely on their faith in the process to alleviate their concerns about the potential negative impacts.

In conclusion, although trainees seem to be able to manage the complexities of deciding whether to have personal therapy during their training, they would certainly benefit from additional support to navigate their way through the journey.

References

- Atkinson, P. (2006). Personal therapy in the training of therapists. *European Journal of Psychotherapy and Counselling*, 8(4), 407-410.
doi:<http://dx.doi.org/10.1080/13642530601038055>
- Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15(2), 219-234.
doi:<http://dx.doi.org/10.1177/1468794112468475>
- Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training*, 46(1), 19-31.
doi:<http://dx.doi.org/10.1037/a0015139>
- British Psychological Society. (2010). *Code of Human Research Ethics*. Leicester: The British Psychological Society. Retrieved August 30, 2013, from www.bps.org.uk
- British Psychological Society. (2013). *Accreditation through partnership handbook: Guidance for clinical psychology programmes*. Leicester: The British Psychological Society. Retrieved February 3, 2014, from www.bps.org.uk/partnership
- Ciclitira, K., Starr, F., Marzano, L., Brunswick, N., & Costa, A. (2012). Women counsellors' experiences of personal therapy: A thematic analysis. *Counselling & Psychotherapy Research*, 12(2), 136-145.
doi:<http://dx.doi.org/10.1080/14733145.2011.645050>
- Cushway, D. (1992). Stress in clinical psychology trainees. *British Journal of Clinical Psychology*, 31(2), 169-179. doi:<http://dx.doi.org/10.1111/j.2044-8260.1992.tb00981.x>

- Daw, B., & Joseph, S. (2007). Qualified therapists' experience of personal therapy. *Counselling & Psychotherapy Research*, 7(4), 227-232.
doi:<http://dx.doi.org/10.1080/14733140701709064>
- Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice*, 36(3), 323-329.
doi:<http://dx.doi.org/10.1037/0735-7028.36.3.323>
- Digiuni, M., Jones, F. W., & Camic, P. M. (2013). Perceived social stigma and attitudes towards seeking therapy in training: A cross-national study. *Psychotherapy*, 50(2), 213-223. doi:<http://dx.doi.org/10.1037/a0028784>
- Freud, S. (1964) [1937]. 'Analysis terminable and interminable'. In J. Sttachev (ed.), *Complete psychological works of Sigmund Freud*. London: Hogarth Press.
- Gillmer, B., & Marckus, R. (2003). Personal professional development in clinical psychology training: Surveying reflective practice. *Clinical Psychology*, 27, 20-23.
- Grimmer, A., & Tribe, R. (2001). Counseling psychologists' perceptions of the impact of mandatory personal therapy on professional development-- an exploratory study. *Counselling Psychology Quarterly*, 14(4), 287-301.
doi:<http://dx.doi.org/10.1080/09515070110101469>
- Holzman, L. A., Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice*, 27(1), 98-101.
doi:<http://dx.doi.org/10.1037/0735-7028.27.1.98>
- Kumari, N. (2011). Personal therapy as a mandatory requirement for counselling psychologists in training: A qualitative study of the impact of therapy on

- trainees' personal and professional development. *Counselling Psychology Quarterly*, 24(3), 211-232.
- Macran, S., & Shapiro, D. A. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology*, 71(1), 13-25.
doi:<http://dx.doi.org/10.1111/j.2044-8341.1998.tb01364.x>
- Moller, N. P., Timms, J., & Alilovic, K. (2009). Risky business or safety net? trainee perceptions of personal therapy: A qualitative thematic analysis. *European Journal of Psychotherapy and Counselling*, 11(4), 369-384.
doi:<http://dx.doi.org/10.1080/13642530903444803>
- Nel, P. W., Pezzolesi, C., & Stott, D. J. (2012). How did we learn best? A retrospective survey of clinical psychology training in the united kingdom. *Journal of Clinical Psychology*, 68(9), 1058-1073.
doi:<http://dx.doi.org/10.1002/jclp.21882>
- Norcross, J. C. (2005). The psychotherapist's own psychotherapy: Educating and developing psychologists. *American Psychologist*, 60(8), 840-850.
doi:<http://dx.doi.org/10.1037/0003-066X.60.8.840>
- Potter, J. (2003). Discourse analysis and discursive psychology. In P.M. Camic, J.E. Rhodes and L. Yardley (Eds). *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 73-94). Washington: American Psychological Association. Retrieved July 24, 2015, from http://www.academia.edu/2474793/Discourse_analysis_and_discursive_psychology
- Rake, C. (2009). Therapy and personal development. In J. Hughes, & S. Youngson (Eds.), *Personal development and clinical psychology* (pp. 108-123). Chichester, West Sussex: Blackwell Publishing Ltd.

- Rake, C., & Paley, G. (2009). Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis. *Psychodynamic Practice: Individuals, Groups and Organisations*, 15(3), 275-294. doi:<http://dx.doi.org/10.1080/14753630903024481>
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE Publications Ltd.
- Smith, J., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London: SAGE Publications Ltd.
- Timms, J. (2010). A taste of our own... therapy: Trainees' rationales for, and experiences of, personal therapy. *Clinical Psychology Forum*, 213, 34-39.
- Wigg, R., Cushway, D., & Neal, A. (2011). Personal therapy for therapists and trainees: A theory of reflective practice from a review of the literature. *Reflective Practice*, 12(3), 347-359.
doi:<http://dx.doi.org/10.1080/14623943.2011.571866>
- Youngson, S., & Hughes, J. (2009). A model of personal development processes. In J. Hughes, & S. Youngson (Eds.), *Personal development and clinical psychology* (pp. 46-61). Chichester, West Sussex: Blackwell Publishing Ltd.
- Zhao-O'Brien, J. (2011). The role of personal professional development in clinical psychology: A trainee's understanding and experience. *Clinical Psychology Forum*, 228, 45-48.

Chapter 3: Reflective Paper

The selves of the trainee clinical psychologist

Overall chapter word count (excluding tables, figures and references): 3922

Introduction

It is now imperative that clinical psychology training programmes facilitate and encourage the personal and professional development (PPD) of their trainees (BPS, 2013). This development includes the ability to self reflect and manage the personal challenges associated with training. Beyond this, however, the concept of PPD appears to be flexible and driven by the model of clinical psychology within which the trainee affiliates themselves with.

Historically, clinical psychologists have been considered as scientist-practitioners, a model that emphasises skills in applying scientific principles to clinical settings. However, as Youngson (2009) highlights, this model, that stipulates that clinical psychologists contribute to the evidence base by conducting research, has failed to appear in reality. The increase in the consideration of the reflective-practitioner model of clinical psychology has emphasised the importance of developing the therapeutic relationship (Cushway & Gatherer, 2003). This has increased the requirement to develop a better understanding of the part that the person of the psychologist plays in the clinical work they undertake.

As a result, when deciding whether to embark on a career as a clinical psychologist, potential trainees need to ask themselves: Is this for *me*? Would *I* be good at this? Would *I* enjoy this? Accordingly, when applying for clinical psychology doctorate training courses, applicants are asked to consider their personal attributes and experiences and how these have shaped their development into potential clinical psychologists. As part of this process, aspiring clinical psychologists may consider which aspects of themselves they are willing to share with others and what they would choose to hide. They may consider whether certain life events are important or whether they represent a weakness or vulnerability that

they would rather keep separate from their professional lives. These aspects of ourselves that we are willing to share (Public Self) and aspects that we prefer to hide (Hidden Self) are captured in the Johari window by Joseph Luft and Harry Ingram (as described by Hughes, 2009, see Figure 3.1).

		Self	
		Known	Unknown
Others	Known	<i>Public Self</i> You and others know	<i>Blind Self</i> Others know but you don't
	Unknown	<i>Hidden Self</i> You know but others don't	<i>Unknown Self</i> You and others don't know

Figure 3.1. The Johari window

Zerubavel and Wright (2012) describe the personal struggles that are experienced by therapists as 'wounds'. They suggest that the therapists' readiness to share their wounds may depend on their perception of what wounds are socially acceptable and the extent to which the wound has healed.

This reflective paper explores personal and professional development in clinical psychology training by considering the different selves of the trainee clinical psychologist. The paper will consider the complexity of assimilating and blending the different selves to facilitate constructive PPD, while maintaining personal wellbeing. The challenges involved in negotiating the many different demands of clinical training will be considered, particularly in relation to the role of therapist,

researcher and student. The role of supervision will also be explored. In an attempt to bring the experiences to life, the paper will include quotes from participants interviewed for the empirical paper and reflections from the reflective diary that was kept while completing the study (Chapter 2).

Developing the Selves of the Trainee Clinical Psychologist

The Self as Psychological Therapist

Like many trainees, I was originally attracted to clinical psychology by the idea of working therapeutically with clients. This desire to help people is often one of the reasons why people embark on a career in clinical psychology (Baker & Nash, 2013) and a considerable amount of our training is dedicated to developing the skills of a psychological therapist.

Our training aims to introduce us to a range of different approaches in the hope that we will develop the necessary toolkit to work with a range of clients in a number of different settings. However, as I approach the end of my training, I continue to feel like a novice in all models: a jack-of-all-trades, master of none. As I have learnt an increasing number of theoretical approaches but struggled to feel confident with any, at times, I have felt inadequate and ineffectual as a therapist.

In the current NHS climate, all professionals are expected to prove their worth, which highlights the importance of being able to justify our role within the context of other professions in the clinical environment. This can be challenging for a trainee faced with difficulties of confidence. Our identity must be distinct from other psychological therapists and we must develop a sense of how we are unique.

The Self as Researcher

The clinical psychologists' engagement with research is one such unique skill. As part of our training, we are required to undertake a number of research endeavours, including a service evaluation project and a doctoral thesis. In keeping with the scientist-practitioner model, clinical psychologists are required to develop research knowledge to apply rigorous research methods to the clinical settings in which they work.

Despite developing research competencies during training, clinical psychologists rarely publish post-qualification (Cooper & Turpin, 2007). This may suggest a belief that publishing research is not an essential requirement for a clinical psychologist, which may account for the reasons why the scientist-practitioner model is falling out of favour.

While I consider research to be an integral part of being a clinical psychologist, I have struggled to develop a feeling of competence in relation to conducting research. The part-time nature in which we engage in research can further confirm doubts about our ability to apply as much specialist knowledge to an area as other disciplines can. When compared to PhD students, for example, clinical psychology students often do not have the time or knowledge to explore a topic area as thoroughly as we may wish to. It can feel challenging to critique existing literature when experiencing self-doubt and concerns about self-competency. Despite coming from a research background, I've been surprised by how challenging the research component has been. I relied heavily on supervision to support my progress and build my confidence in my abilities. The process of supervision allowed me to engage in 'reflection on action' (Lavender, 2003), by considering what I have done

so far and deciding on the best route to take next, rather than being overwhelmed by the enormity of the tasks to come.

Reflecting on comments I made in my reflective journal when deciding on the topic for my empirical paper, I initially felt reluctant to conduct research using clinical psychology trainees as participants. It felt like an easy option and I recall wanting to research ‘real world’ problems outside of, what seemed like, the artificiality of a training environment. The implications of research with trainees felt limited in that the findings would impact such a small percentage of the population. My assumption reflects the ideas discussed in Chapter 1: that the professional is not the priority, but the clients must come first.

I am surprised by my initial reluctance to explore the experiences of trainees. Through completing this project, and working through my training, I have seen first-hand the importance of looking after the professional and the person behind the professional as much as the clients they support. This has drawn my attention to the extent to which research studies are driven by current policies, media attention and the ‘hot topic’ of the moment. I have seen the value of ensuring that all aspects of a service structure are considered and attended to through research.

The Self as Client

One of the options available to clinical psychology trainees during their training is personal therapy. By becoming clients ourselves, we are able to reduce the ‘them and us’ divide between clients and health professionals. However, it is not made immediately clear by the profession as to why you would engage in personal therapy as a clinical psychologist, or even whether it is necessary. As discussed in Chapter 2, trainees are left to explore independently why personal therapy would be

helpful for them. Some trainees in the study appeared content with having therapy to explore more personal difficulties and felt that training provided an opportunity or excuse to tackle these issues. Others wished to use therapy to ‘park’ their personal responses in order to progress with their clinical work more effectively. This need to know yourself in order to work effectively with clients is well-documented as one of the ways in which therapy supports the development of therapists (Macran & Shapiro, 1998).

One aspect of the experience of personal therapy is that it provides the opportunity to experience the self as a client and ‘seeing things from the other side’. This form of reflection is described by Stedmon, Mitchell and Johnstone (2003) as ‘learning by doing’. Participants in the empirical paper described the advantage of being able to see what therapy would be like from the client’s perspective:

It would be useful to see what it is like for other people going through that process...It’s hard to...say ‘oh I’m a clinical psychologist’ if you...haven’t had any therapy yourself or...know what it’s like from the other side of things.

(Beth, 239-242)

The Self as Trainee Clinical Psychologist

Training to be a clinical psychologist is ultimately a job characterised by a salary and all the benefits that accompany employment in the NHS. However, as a trainee I have had a sense of being ‘not-quite-a-clinical-psychologist’ rather than having a distinct professional identity. Although trainees fulfill a designated role in the wider health service, on a day-to-day basis it can be hard to feel settled and

secure in our professional role. As we move through our various placements every six months we begin to realise the transient nature of our positions in teams. We lack consistency, or as the participants in the empirical study put it, we can't settle.

It comes in waves...being unsettled and the fact that...you are constantly moving around so you...settle into a team after 6 months and then you're...moved to the next team and then you have to do it all again...and it's very dependent on the team, isn't it, and your supervisor as to... how well you fit in...It must be weird for teams as well...they don't necessarily always want to... invest that much time in someone that's only going to be there for...4 ½ months.

(Beth, 168-176)

Hearing the participants' experiences of being unsettled and constantly being moved on brought to mind the concept of a nomad. This approach to living is centred around the idea of moving from location to location in order to avoid draining any particular environment of its resources. I wonder if trainee clinical psychologists get this sense each time they move on to pastures new. There feels like a pressure to develop as much as possible from each experience while not being a burden and taking more than the teams are able to afford.

The only thing that ends up being consistent during training is ourselves. As the course has progressed I have realised that my job during training is actually to develop myself. All of the requirements within my 'job' have been focused on developing myself as a clinical psychologist, rather than particularly fulfilling the need of a service. This can feel like quite a self indulgent experience given the

amount of money and time that is invested in each trainee and places pressure on the self to develop according to the expectations placed upon us.

The Self of the Psychologist

Due to the all-consuming nature of clinical psychology training and the ongoing emphasis on developing the skills required to ‘do the job’, it can be hard to remember to take time to reflect on the self of the psychologist: our personal identities. We are encouraged to put our personal lives on hold and put ourselves in a frame of mind in which we can properly develop ourselves as clinical psychologists. Time to engage in activities purely for the self can become more and more limited as we move through the training experience.

The demands of the academic work alongside the emotionally challenging clinical work can take its toll. Even trainees with well-developed coping strategies and support networks can struggle under the pressure. Therefore, stress in clinical psychology trainees has been highlighted as high priority for training providers (Pakenham & Stafford-Brown, 2012). However, there is a fear amongst trainees that by showing their personal struggles they may put their chances of professional success under threat. Withholding from supervisors for fear of the potential negative impacts of disclosing information was also captured in the literature in Chapter 1 (Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley & Hoffman, 2008; Spence, Fox, Golding & Daiches, 2014). Caroline also described this experience in the empirical study:

I think I was always...nervous that if I acknowledged that something was difficult then people might take away responsibilities or take away the

opportunity to work in someway...or would think that I wasn't cut out for this job.

(Caroline, 343-346)

Ultimately, I have found that there is a need to consider the self as one of the areas for development during the process of training. It is hard to imagine how this would not be essential given the need for adaptation that is required throughout the training process. For example, the impact on personal time of having an increased commute to placement or a change in teaching days can be considerable.

The self of the psychologist is like the shell that holds the other selves, a tree that supports the bracketing fungus. In Chapter 2, Amy succinctly put her desire to work on herself before anything else:

I've got to be a better *me* before I can be a better psychologist.

(Amy 358-359)

Assimilating the Selves

It would be naïve to think that we could independently develop the different parts of the trainee clinical psychologist without some conflict, confusion or compromise. As Gillmer and Marckus (2003, p. 21) highlight, "PPD necessarily invites a deconstruction of self during training, which is in direct conflict with the super-competent image demanded of trainee applicants".

One of the most challenging aspects of clinical psychology training is the need to understand and develop the different parts of ourselves concurrently.

Illustrative examples will now highlight my experiences of the complexities of managing this task.

The Researcher versus the Therapist

One of the most challenging stages of my clinical training experience was the point when I was becoming increasingly focused on completing my thesis while continuing to see clients on placement. I was working in a counselling environment that focused on using the self of the therapist as the therapeutic tool. This approach was novel to me and required a considerable amount of development of my professional skills. I had to think flexibly, openly and curiously about my clients while also feeling like I lacked the skills to support them effectively.

Alongside this, I was trying to develop my skills in systematically critiquing research publications, something which required distinctly different skills to my clinical work. I came to realise that applying the wrong skill to the wrong task could result in negative consequences for both myself and my clients. While I was stuck in the mindset of methodically evaluating research literature, I was far less able to support my clients in the way they needed me to.

I have found that training has continually placed conflicting demands on me at a time when I was working to develop and practise new skills in another area of my development. However, once again, I found support in supervision. Having an opportunity to explore my experiences and unpick why I was feeling stuck with clients was a valuable learning opportunity in itself. I felt able to realise what I was asking of myself and the complex task I was trying to undertake, which facilitated feelings of compassion towards myself.

I have also found the struggles of switching between researcher and therapist challenging while conducting my research study. When hearing the trainees in my empirical study describe their struggles, it felt challenging to be unable to offer compassion, empathy or solutions. One significant difference between working with clients in a therapeutic setting and interviewing participants in a research study is the nature of the relationship and the role which I play within that relationship. When working with clients, I am able to provide insights, interpretations, thoughts and experience. In contrast, when exploring participants' experiences in an IPA study (Smith, Flowers & Larkin, 2009), I aimed to say as little as required in order to focus on the participants' experience and how they have made sense of it.

As Smith et al., (2009) highlight:

You will need to find a comfortable 'research persona' for yourself. This is not always as easy as it sounds, even if you are used to dealing with people in a professional context. Research interviewing generally requires that we put aside certain common interactional habits (such as: sharing our experience and knowledge, exercising our therapeutic capacity, academic authority or clinical judgement; demonstrating the full extent of our empathy; or steering participants towards new and more positive appraisals of their problems). In their place we have to do a lot of highly engaged listening and some well-timed, and sensitive, questioning. (p.67)

The 'Expert' versus the Novice

When moving from one role to another within a professional context, there is a noticeable shift between being in the position of 'expert' to being in the position of novice. For example, within one day on placement trainees may alternate between being placed in the 'expert' role by a client to being the novice in supervision.

The question as to who is the 'expert' is also an important factor when undertaking research. Our epistemological position is an important consideration when developing a research design. It is important to note whether we believe that we can somehow 'know' what our clients or participants think or feel or whether we feel that experiences are subjective and interpretable.

The parallels of working with clients and conducting semi-structured interviews as part of a research study are considerable. Having completed my empirical paper, I have realised my stance with clients closely follows that of the philosophy and underpinning of IPA (Smith et al., 2009). I believe that when working with clients I am trying to make sense of their sense-making of their experiences. After all, as a therapist you often only receive information that the client is providing you with, rather than objective accounts of events. This places the client in the expert role and the therapist in the role of understanding the second-hand information they receive.

On reflection, I feel my empirical research project would have benefitted from more involvement from my participants. Coming from the position that my participants were the expert, the project may have been enhanced by incorporating more of their insights into the process, as Yardley (2000) suggests. I would have valued more time to revisit my final themes with my participants and explore the ideas with them further.

The Self versus the Researcher

Interviewing a participant in a research study is not only complicated by the need to manage how the researcher can guide or lead the participant. It is also important to be aware of how the researcher is affected by their experience of the participant. Being an eligible participant for my empirical study meant that the topics being discussed were often very applicable to my own experiences. This led me to compare my experiences with others and wonder why mine had been different or question whether I should have experienced things differently. For example, hearing others' experiences of their relationship with their therapist led me to question whether mine was the same. This sense of comparing self to others emerged as a theme for the participants in the empirical paper and appears to be a common trait amongst clinical psychology trainees.

Looking back at comments in my reflective diary, I questioned with myself why I had chosen a topic that was 'so close to home'. It occurred to me that I may have found it simpler to explore a topic that was on the periphery of my experience. Perhaps this was evidence that I wanted to explore this topic for my own benefit, to resolve some experiences that I had found difficult or that I wanted to better understand.

I have reflected on how we are often motivated by our own experiences and this has highlighted to me the importance of spending time reflecting on our positions towards topics we approach and engaging in the reflexivity that is so important in qualitative research (Yardley, 2000). The opportunity to 'bracket' my beliefs and assumptions during the research study allowed me to explore my participants' experiences with a more open mind. I felt, at least to some extent, that I

was able to get into their world and learn from them. However, through hearing their reflections and experiences I was also able to develop clarity about my own experiences.

Although, I feel I was able to maintain the position of the objective researcher while in the room with the participant, I was more than aware that internally other parts of myself had been activated. Following this realisation, I began to contemplate which source of support I should approach. I considered whether I should discuss this with my research team given that my reflections emerged while I was interviewing participants. I also wondered whether it would be more appropriate to discuss my ideas in personal therapy as my reflections were related to my therapy experience. It also occurred to me to continue to internally reflect and see if it resolved itself.

I was aware before I began the research study that it would be challenging to use the methodology I was aiming to use without it exposing aspects of my self. I was aware that it would be important for the reflexivity of the project to declare my position with personal therapy and reveal that I had engaged in personal therapy myself. I struggled to decide whether this would expose any part of my personal self. This experience highlighted to me the reflective nature of the way I practice. I explored the possible repercussions of revealing this information about myself and how it may impact on how others see me. It brought to mind, the process I go through as a therapist when deciding whether to disclose information to my supervisor. I might query what the risks and benefits are before deciding whether I should reflect on something by myself or seek support. I may wonder whether I have a duty as an ethical professional to declare an experience I am having.

The 'Developed' Selves

As a third year trainee coming towards the end of training, I have reflected on what stage of development I had anticipated reaching before qualifying as a clinical psychologist. Caroline described her expectations of completing her self development:

That's the really nice thing about personal development is that it never actually ends so you're never done.

(Caroline, 388-389)

During training, we are assessed against the parameters and expectations of what is expected of a clinical psychologist but I wonder what assessment is made of ourselves at the end of the process. Although, I remain unclear about exactly what a clinical psychologist 'should' look like, I have realised how essential it is that the different parts of ourselves can work together within the professional role we undertake.

Contrary to my expectations, I have spent a considerable proportion of my training experience exploring my self in relation to my role as a clinical psychologist. Although, at times, this felt self-indulgent, it also did not feel like there was a choice to be made. Whether I liked it or not, all parts of myself had to be on board to get to the end of the journey.

References

- Baker, M., & Nash, J. (2013). Women entering clinical psychology: Qualitative narratives of career attraction of female clinical psychology trainees in the UK. *Clinical Psychology & Psychotherapy*, 20(3), 246-253.
- British Psychological Society. (2013). *Accreditation through partnership handbook: Guidance for clinical psychology programmes*. Leicester: The British Psychological Society. Retrieved February 3, 2014, from www.bps.org.uk/partnership
- Cooper, M., & Turpin, G. (2007). Clinical psychology trainees' research productivity and publications: An initial survey and contributing factors. *Clinical Psychology & Psychotherapy*, 14(1), 54-62. doi:<http://dx.doi.org/10.1002/cpp.513>
- Cushway, D., & Gatherer, A. (2003) Reflecting on reflection. *Clinical Psychology*, 27, 6-10.
- Gillmer, B., & Marckus, R. (2003) Personal professional development in clinical psychology training: Surveying reflective practice. *Clinical Psychology*, 27, 20-23.
- Hess, S. A., Knox, S., Schultz, J. M., Hill, C. E., Sloan, L., Brandt, S., . . . Hoffman, M. A. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Research*, 18(4), 400-411. doi:<http://dx.doi.org/10.1080/10503300701697505>
- Hughes, J. (2009). What is personal development and why is it important? In J. Hughes, & S. Youngson (Eds.), *Personal development and clinical psychology* (pp. 24-45). Chichester, West Sussex: Blackwell Publishing Ltd.
- Lavender, T. (2003) Redressing the balance: the place, history and future of reflective practice in clinical training. *Clinical Psychology*, 27, 11-15.

- Macran, S., & Shapiro, D. A. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology*, 71(1), 13-25.
doi:<http://dx.doi.org/10.1111/j.2044-8341.1998.tb01364.x>
- Pakenham, K. I., & Stafford-Brown, J. (2012). Stress in clinical psychology trainees: A review of current research and future directions. *Australian Psychologist*, 47, 147-155.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE Publications Ltd.
- Spence, N., Fox, J. R., Golding, L., & Daiches, A. (2014). Supervisee self-disclosure: A clinical psychology perspective. *Clinical Psychology & Psychotherapy*, 21(2), 178-192. doi:<http://dx.doi.org/10.1002/cpp.1829>
- Stedmon, J., Mitchell, A., & Johnstone, L. (2003) Making Reflective Practice real: problems and solutions in the South West. *Clinical Psychology*, 27, 30-33.
- Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215-228. doi: 10.1080/08870440008400302
- Youngson, S. (2009). Personal development in clinical psychology: The context. In J. Hughes, & S. Youngson (Eds.), *Personal development and clinical psychology* (pp. 8-23). Chichester, West Sussex: Blackwell Publishing Ltd.
- Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, 49(4), 482-491. doi:<http://dx.doi.org/10.1037/a0027824>

Appendices

Appendix A: Author Guidelines for Clinical Psychology and Psychotherapy



Clinical Psychology & Psychotherapy

Clinical Psychology & Psychotherapy

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Edited By: Paul Emmelkamp and Mick Power

Impact Factor: 2.59

ISI Journal Citation Reports © Ranking: 2013: 28/111 (Psychology Clinical)

Online ISSN: 1099-0879

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Reference style . The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication .

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both

first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited .

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary .

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year .

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears .

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others") .

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author .

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Journal Article

Gardikiotis, A., Martin, R., & Hewstone, M. (2004). The representation of majorities and minorities in the British press: A content analytic approach. *European Journal of Social Psychology*, 34 , 637-646. DOI: 10.1002/ejsp.221

Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press.

Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on.

The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials* . Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website:

http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion* . Retrieved August 3, 2001, from <http://www.psywww.com/psyrelig/psyrelpr.htm>

Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence*, 15 , 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology*, 20 , 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

Article or Chapter in an Edited Book

Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

*The Digital Object Identifier (DOI) is an identification system for intellectual property in the digital environment. Developed by the International DOI Foundation on behalf of the publishing industry, its goals are to provide a framework for managing intellectual content, link customers with publishers, facilitate electronic commerce, and enable automated copyright management.

Illustrations. Upload each figure as a separate file in either .tiff or .eps format, the figure number and the top of the figure indicated. Compound figures e.g. 1a, b, c should be uploaded as one figure. Grey shading and tints are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Where a key to symbols is required, please include this in the artwork itself, not in the figure legend. All illustrations must be supplied at the correct resolution:

- Black and white and colour photos - 300 dpi

- Graphs, drawings, etc - 800 dpi preferred; 600 dpi minimum
- Combinations of photos and drawings (black and white and colour) - 500 dpi

The cost of printing **colour** illustrations in the journal will be charged to the author. The cost is approximately £700 per page. If colour illustrations are supplied electronically in either **TIFF** or **EPS** format, they **may** be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the *Wiley Online Library* site.

POST ACCEPTANCE

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Cite EarlyView articles. To link to an article from the author's homepage, take the DOI (digital object identifier) and append it to "http://dx.doi.org/" as per following example: DOI 10.1002/hep.20941, becomes <http://dx.doi.org/10.1002/hep.20941>.

Appendix B: Systematic Review Inclusion and Exclusion Criteria

Criteria	Included	Excluded
Type of professional	<ul style="list-style-type: none"> ✓ Counsellor ✓ Clinical Psychologist ✓ Therapist ✓ Psychotherapist 	<ul style="list-style-type: none"> ✗ Psychiatrists ✗ Nurses ✗ Social Workers ✗ GPS ✗ Occupational Therapist ✗ Teacher ✗ Physiotherapists ✗ Pastoral/Clergy ✗ Coaching Psychologists ✗ Dentists ✗ Vocational counsellors ✗ Supervisors in training ✗ Online counsellor ✗ Undergraduate Psychology students ✗ Substance use disorder (SUD) counsellors
Style of Supervision	<ul style="list-style-type: none"> ✓ Real-life therapy ✓ Supervision in the context of a clinical trial ✓ Individual supervision 	<ul style="list-style-type: none"> ✗ Group supervision ✗ Triadic supervision ✗ Role-play ✗ Art-based supervision ✗ Supervision of supervision ✗ Simulated supervision ✗ Peer supervision ✗ Supervision of group work
Type of ‘Therapy’	<ul style="list-style-type: none"> ✓ CBT ✓ Counselling ✓ Psychotherapy ✓ Couples therapy ✓ Group therapy 	<ul style="list-style-type: none"> ✗ Family therapy ✗ Online/email therapy ✗ Hypnotherapy ✗ Art therapy ✗ Music therapy ✗ Play therapy ✗ Yoga therapy
Type of data reported	<ul style="list-style-type: none"> ✓ Studies that set out to examine some aspect of the IMPACT of supervision on the supervisee, their practice and/or their clients ✓ Outcomes of supervision reported 	<ul style="list-style-type: none"> ✗ Satisfaction with supervision/supervisor only data reported ✗ Discursive articles - No systematic collection of data related to supervisees ✗ Description of supervision only ✗ Case Studies
Availability	<ul style="list-style-type: none"> ✓ Available 	<ul style="list-style-type: none"> ✗ Unavailable

Appendix C: Quality Assessment Checklist (QAC)

Adapted from Caldwell, Henshaw & Taylor (2005), CASP (2013) and Downs & Black (1998).

Quantitative Methodologies		Yes or N/A (2)	Partially (1)	No (0)	Can't tell (0)
Rationale	1. Rationale: Is the rationale for undertaking the research clearly outlined?				
	2. Aim: Is the aim of the research clearly stated?				
	4. Methodology: Is the methodology identified and justified?				
Methodology	5. Study Design: Is the study design clearly identified, and is the rationale for choice of design evident?				
	6. Key Variables: Is there an experimental hypothesis clearly stated? - Predictions Are the key variables clearly defined?				
	7. Study Population: Is the population identified?				
	8. Supervision: Is the supervision process clearly described?				
	9. Sample: Is the sample adequately described and reflective of the population?				
	10. Data Collection: Is the method of data collection valid and reliable?				
	11. Data Analysis: Is the method of data analysis valid and reliable?				
	12. Main Findings: Are the main findings of the study clearly described? Are the results presented in a way that is appropriate and clear?				
Results	13. Results: Are the results generalizable?				
	14. Discussion: Is the discussion comprehensive?				

Qualitative Methodologies		Yes or N/A (2)	Partially (1)	No (0)	Can't tell (0)
Rationale	1. Rationale: Is the rationale for undertaking the research clearly outlined?				
	2. Aims: Is the aim of the study clearly stated?				
	3. Ethical Issues: Are all ethical issues identified and addressed?				
	4. Methodology: Is the methodology identified and justified? Is a qualitative approach appropriate?				
Methodology	5. Study Design: Are the philosophical background and study design identified and the rationale for choice of design evident?				
	6. Study Context: Is the context of the study outlined (particularly the process of supervision)?				
	7. Participants: Is the selection of participants described and the sampling method identified? Was the recruitment strategy appropriate to the aims of the research?				
	8. Relationship: Has the relationship between researcher and participants been adequately considered?				
	9. Data Collection: Is the method of data collection auditable?				
	10. Data Analysis: Is the method of data analysis credible and confirmable? Was the data analysis sufficiently rigorous?				
Results	11. Main Findings: Are the main findings of the study clearly described?				
	12. Results: Are the results transferable?				

Appendix D: Quality Assessment Checklist (QAC) Ratings - Quantitative

Quantitative	Anderson, Crowley, Patterson & Heckman (2012)	Grossl, Reese, Norsworthy & Hopkins (2014)	Lenz, Sangganjanav- anich, Balkin, Oliver & Smith (2012)	McAleavey, Castonguay & Xiao (2014)	Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands & Chisholm (2009)	Sterner (2009)	Tracey, Bludworth & Glidden-Tracey (2012)
1. Rationale	Partially (1)	Partially (1)	Yes (2)	Yes (2)	Yes (2)	Partially (1)	Partially (1)
2. Aims	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partially (1)	Yes (2)
3. Ethical Issues	No (0)	No (0)	Yes (2)	Can't tell (0)	No (0)	Can't tell (0)	Can't tell (0)
4. Methodology	Yes (2)	Yes (2)	Partially (1)	Partially (1)	Yes (2)	No (0)	Yes (2)
5. Study Design	Partially (1)	Yes (2)	Partially (1)	Partially (1)	Yes (2)	Yes (2)	Can't tell (0)
6. Key Variables	Yes (2)	No (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
7. Study Population	Yes (2)	No (0)	Yes (2)	Yes (2)	No (0)	Yes (2)	Partially (1)
8. Supervision	Partially (1)	No (0)	Partially (1)	No (0)	No (0)	No (0)	Partially (1)
9. Sample	Yes (2)	Partially (1)	Partially (1)	Partially (1)	Partially (1)	No (0)	Can't tell (0)
10. Data Collection	Yes (2)	Partially (1)	Yes (2)	Partially (1)	Partially (1)	Yes (2)	Partially (1)
11. Data Analysis	Can't tell (0)	Partially (1)	Can't tell (0)	Can't tell (0)	Yes (2)	Yes (2)	Can't tell (0)
12. Main Findings	No (0)	Partially (1)	Can't tell (0)	No (0)	Yes (2)	Partially (1)	Can't tell (0)
13. Results	No (0)	No (0)	No (0)	Partially (1)	Partially (1)	Can't tell (0)	No (0)
14. Discussion	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partially (1)	Yes (2)
Total (Out of 28)	17	13	18	15	19	14	10
% Score	61%	46%	64%	54%	68%	50%	36%

Appendix D: Quality Assessment Checklist (QAC) Ratings - Qualitative

Qualitative	Ancis & Marshall (2010)	Andersson, King & Lalande (2010)	Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley & Hoffman (2008)	Knox, Burkard, Edwards, Smith & Schlosser (2008)	Spence, Fox, Golding & Daiches (2014)	Starr, Ciclitira, Marzano, Brunswick & Costa (2013)
1. Rationale	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
2. Aims	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
3. Ethical Issues	Partially (1)	Yes (2)	Partially (1)	No (0)	Partially (1)	Yes (2)
4. Methodology	Yes (2)	Yes (2)	Partially (1)	Yes (2)	Yes (2)	Yes (2)
5. Study Design	Partially (1)	Partially (1)	Yes (2)	Yes (2)	Partially (1)	Yes (2)
6. Study Context	Partially (1)	Yes (2)	No (0)	Partially (1)	Partially (1)	Partially (1)
7. Participants	Yes (2)	Yes (2)	Partially (1)	Yes (2)	Yes (2)	Partially (1)
8. Relationship	No (0)	No (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
9. Data Collection	Yes (2)	Partially (1)	Yes (2)	Partially (1)	Yes (2)	Partially (1)
10. Data Analysis	Partially (1)	Partially (1)	Partially (1)	Partially (1)	Yes (2)	Yes (2)
11. Main Findings	Yes (2)	Partially (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
12. Results	Partially (1)	Yes (2)	Partially (1)	Partially (1)	Partially (1)	Partially (1)
Total (Out of 24)	17	18	17	18	20	21
% Score	71%	75%	71%	75%	83%	88%

Appendix E: Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



Participant Information Sheet

Study title:

Exploring decisions to engage in personal therapy during clinical psychology training

A study by Sarah Bell, Jacky Knibbs, Claudie Fox and Delia Cushway
Coventry & Warwick Universities Doctorate in Clinical Psychology

We would like to invite you to take part in a research study. Before you decide whether you want to take part in the study, it is important that you understand why we are doing the research and what it will involve. Please do not hesitate to contact the researcher, or one of her supervisors, if you have any questions or concerns before deciding whether you want to take part or not.

What is the purpose of the study?

The aim of the study is to explore the processes that trainee clinical psychologists go through when deciding whether to have personal therapy during their training.

Why have I been chosen?

You have been chosen because you are currently training on the Coventry and Warwick Universities 'Doctorate in Clinical Psychology' training course, or you have recently qualified from this course. We are interested to know what process you have been through while deciding whether to have personal therapy during training. Therefore, you can take part as long as you have thought about having personal therapy at some point during your training. It doesn't matter whether you have had therapy during training or not.

Do I have to take part?

No. It is entirely your choice whether you decide to take part or not. If you choose to take part, you will be asked to sign a consent form to indicate that you have read and understood this participant information sheet and agree to take part in the study. You can still change your mind and withdraw from the study at any time within the two weeks following your participation in the study. If you decide to withdraw during this time, you can contact the researcher who will destroy all of your data and it will not be used in the study. There are no consequences of deciding to withdraw your data from the study.

What will happen if I agree to take part?

The study involves participating in an interview. You will be asked questions about the process you went through when deciding whether to have personal therapy during your

PIS v1.1 23.06.2014

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Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

training. If you would like to take part, you can contact the researcher via email or leave a telephone message with the clinical psychology office (details below). You will then be contacted to arrange an interview date, time and venue that are convenient for you.

The interview will last approximately one hour. However, the length of each interview varies in order to fit with the individual experiences of the participants, but the interview will last no longer than 90 minutes. The interview will be voice recorded, for the purpose of data analysis, and will then be transcribed. However, before the recording begins, you will have an opportunity to ask questions about the study and you will be asked to sign a consent form.

What are the possible disadvantages and risks of taking part?

If you choose to take part in the study, you will be invited to say as much as you feel comfortable with. You are free to decline to answer any of the questions. However, it is also possible that taking part in the study may evoke some emotional distress. If this happens, please remember that we can stop the interview at any time. If you feel the interview has caused you any kind of distress, I will have copies of the West Midlands Therapy Network Register available for you to take away with you. Alternatively, you may wish to contact your GP.

What are the possible benefits of taking part?

Participants will not directly receive any rewards for taking part in the research study. However, you may value an opportunity to reflect on your experiences during your training course. It is hoped that the results of the study will inform future trainees and guide course teams in their advice and support that they give to their trainees.

Will my information be kept confidential?

Yes. The recording taken during the interview will be kept as a password protected file on the researcher's password-protected computer. The recording will be transcribed by the researcher or an employed transcriber that is unrelated to the Coventry and Warwick Doctorate training course. The transcription will be stored, as a password protected file, on the researcher's personal password-protected computer. The transcription will be anonymised to ensure that you are not identifiable from the written transcript. A paper copy of the transcription will be used for analysis by the researcher. The transcript will be stored in a secure location (a locked filing cabinet). This anonymised transcript may also be reviewed by the researcher's supervisors and other members of the clinical psychology team for purposes of validation. All consent forms will be stored in a separate secure location (a locked filing cabinet) to the transcribed interview.

Following completion of the study, your information will be stored securely by Coventry University for five years before being destroyed, in accordance with the British Psychological Society (BPS) guidelines. Information gained from the interviews, including anonymous quotes and extracts, may be included in the final paper that

contributes to the researcher's doctoral thesis and any further dissemination e.g. journal articles, conference presentations.

What will happen to the results of the research study?

The results of the study will be written up and presented in the final paper that contributes to the researcher's doctoral thesis. The results may also be published in psychology or mental health journals. If you would like to receive a summary of the findings, please contact the researcher (see contact details below).

Who is organizing and funding the research?

The research is organized by Sarah Bell, who is a Postgraduate student on the 'Coventry and Warwick Universities Doctorate in Clinical Psychology' training course. This project is not externally funded.

Who has reviewed the study?

The study has been through the Coventry Peer Review process and has been approved.

Contact for Further Information:

Researcher:	Sarah Bell	Trainee Clinical Psychologist: Clinical Psychology Doctorate, Faculty of Health and Life Sciences, Coventry University, James Starley Building, Priory Street, Coventry, CV1 5FB Tel: 024 7688 7630 Email: bells8@uni.coventry.ac.uk
Clinical Supervisors:	Jacky Knibbs	Clinical Psychology Doctorate, Faculty of Health and Life Sciences, Coventry University, James Starley Building, Priory Street, Coventry, CV1 5FB Tel: 024 7688 7630 Email: j.knibbs@coventry.ac.uk
	Prof. Delia Cushway	Emeritus Professor of Clinical Psychology Clinical Psychology Doctorate, Faculty of Health and Life Sciences, Coventry University, James Starley Building, Priory Street, Coventry, CV1 5FB Tel: 024 7688 7630 Email: d.cushway@gmail.com
Academic Supervisor:	Dr Claudie Fox	Department of Psychology, University of Warwick, Coventry, CV4 7AL Tel: 024 7652 3176 Email: claudie.fox@warwick.ac.uk

Appendix F: Semi-Structured Interview Schedule

<p style="text-align: center;">Main Question:</p> <p>* So, how have you found your training so far?</p> <p>* Can you tell me about a time when you have thought about having therapy during your training?</p> <p style="padding-left: 20px;">→ What got you starting to think about having therapy?</p> <p style="padding-left: 20px;">→ What was happening at the time?</p>	
<p>Prompts:</p> <p>Can you tell me a bit more about that?</p> <p>What did ____ mean to you?</p> <p>Can you tell me what you were thinking?</p> <p>How did you feel?</p> <p>How?</p> <p>Why?</p>	<p>Comments:</p>
<p>Understanding of required decision:</p> <ul style="list-style-type: none"> What was it like making the decision? How clear were you about the decision you had to make? To what extent was your experience familiar to you? 	<p>Internal/external influences:</p> <ul style="list-style-type: none"> Thought processing/reflections Course team involvement Other trainees involvement
<p>Barriers:</p> <p>Were there any barriers to you having therapy or things that put you off?</p> <ul style="list-style-type: none"> Time/cost Fears Confidentiality 	<p>Other options considered/attempted:</p> <p>Did you consider any other options apart from therapy?</p> <ul style="list-style-type: none"> Talking to friends/family Professional support (supervision) Self-help (yoga, mindfulness) Drug-use, alcohol, exercise
<p>Anticipated outcome:</p> <p>What did you anticipate the outcome of therapy would be?</p>	<p>Current experience:</p> <ul style="list-style-type: none"> Do you feel that you still have a decision to make? What is your current experience in relation to therapy during training?
<p>Final Question:</p> <p>Is there anything else that you would like to add about your experience of deciding whether to have personal therapy or not?</p>	

Appendix G: Description of Study for Participants

Exploring decisions to engage in personal therapy during clinical psychology training

Introduction to the study:

[Read by Researcher]

During the interview, I want to explore your experiences of deciding whether to have personal therapy during your training. I am interested in *your* experience and how you understand it so that means that there are no right or wrong answers.

As I'm interested in your experiences it might be that I won't end up saying very much during the interview. It also might seem at times like the questions I ask are a bit obvious but it's because I'm trying to understand things from your perspective. Please remember that you can take your time with responding and it's absolutely fine to take time to think if you want to.

How long the interview will last depends on what you want to say really, but I would have thought it will last between about 45 minutes and an hour and a half.

I'm going to be recording the interview so that I can transcribe it afterwards. The laptop and phone here will both be recording throughout. I'll let you know when I'm going to start the recording.

[Asked to Participant]

Is there anything that you're not clear about or is there anything that you want to ask before we begin the interview?

[Questions answered accordingly]

[Consent forms signed]

Appendix H: Consent Form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
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Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D., CPsychol

THE UNIVERSITY OF
WARWICK



Consent Form

Study title:

Exploring decisions to engage in personal therapy during clinical psychology training
A study by Sarah Bell, Jacky Knibbs, Claudie Fox and Delia Cushway
Coventry & Warwick Universities Doctorate in Clinical Psychology

Please read each of the following statements and initial in the boxes...

1. I confirm that I have read and understand the attached Participant Information Sheet (v1.1 - 23.06.2014) and by signing below I consent to participate in this study. ☐
2. I understand that I will be asked to participate in an interview that will be voice-recorded. ☐
3. I understand that I have the right to withdraw from the study at any time during the interview itself (without giving a reason). ☐
4. I understand that I also have the right to change my mind about participating in the study for a period of two weeks after the interview has been completed. ☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Contact for Further Information:

Sarah Bell
(Trainee Clinical
Psychologist)

Clinical Psychology Doctorate
Faculty of Health and Life
Sciences, Coventry University,
James Starley Building,
Priory Street,
Coventry, CV1 5FB

Tel: 024 7688 7630
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Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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Appendix I: Demographics Form

Demographics

Please tick the appropriate box corresponding to your age, gender and current year of training.

Age

< 20	<input type="checkbox"/>
20 - 24	<input type="checkbox"/>
25 - 29	<input type="checkbox"/>
30 - 34	<input type="checkbox"/>
35 - 39	<input type="checkbox"/>
40 - 44	<input type="checkbox"/>
45 - 49	<input type="checkbox"/>
50 - 54	<input type="checkbox"/>
55 - 59	<input type="checkbox"/>
60 +	<input type="checkbox"/>

Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Other	<input type="checkbox"/>

Current Year of Training

1	<input type="checkbox"/>
2	<input type="checkbox"/>
3	<input type="checkbox"/>
Recently Qualified	<input type="checkbox"/>

Appendix J: Ethical Approval Confirmation

Exploring decisions to engage in personal therapy during clinical psychology training	P22619
REGISTRY RESEARCH UNIT ETHICS REVIEW FEEDBACK FORM (Review feedback should be completed within 10 working days)	
Name of applicant: Sarah Bell	
Faculty/School/Department: [Faculty of Health and Life Sciences] Clinical Psychology	
Research project title: Exploring decisions to engage in personal therapy during clinical psychology training	
Comments by the reviewer	
1. Evaluation of the ethics of the proposal:	
Section 3. More details about the project 'Is it expected...' Change to 'it is expected...'	
Section 6. Confidentiality 'The transcription will be anonymised to ensure that you are not identifiable from the written transcript.' Change to 'The transcription will be anonymised to ensure that they are not identifiable from the written transcript.'	
2. Evaluation of the participant information sheet and consent form:	
Participant Information sheet What are the possible disadvantages and risks of taking part? 'If you chose...' Change to 'If you choose...'	
Consent Form Please include a box beside each of the consent statements (I have read and understand the attached Participant Information "...I understand that I will be asked to participate...; I understand I have the right to withdraw...; I understand that I also have the right to change my mind...") and request participants to initial these to indicate they confirm with each of the statements, in addition to their signature at the end of the consent form	
3. Recommendation: (Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).	
<input type="checkbox"/>	Approved - no conditions attached
<input checked="" type="checkbox"/>	Approved with minor conditions (no need to re-submit)
<input type="checkbox"/>	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
<input type="checkbox"/>	Rejected for the following reason(s) – please use other side if necessary
<input type="checkbox"/>	Not required
Name of reviewer: Anonymous	
Date: 14/04/2014	
Sarah Bell	Page 1 of 1
20 April 2015	

Appendix K: Interpretive Phenomenological Analysis: Stages of Analysis

(Smith, Flowers & Larkin, 2009)

Stage of Analysis	Description of process
Stage 1: Reading and Re-reading	Immersion in the data was begun by reading and re-reading a participant's transcript. The audio-recording was used to encourage immersion in the particular participant's world.
Stage 2: Initial Noting	Further engagement with the data was achieved during line-by-line analysis of the transcripts. Firstly, the researcher went through the transcript and underlined any text that appeared salient. Detailed notes and comments relating to significance of the underlined text were then added to the right hand side of the transcript. Attention was also paid to descriptive, linguistic and conceptual aspects of the transcript.
Stage 3: Developing emergent themes	Detailed notes were analysed to identify emergent themes that captured the participant's experience and the researcher's interpretation of that experience. These themes were noted on the left hand side of the transcript.
Stage 4: Searching for connections across emergent themes	The researcher explored how the emergent themes fitted together. Some themes were disregarded at this stage if they did not fit within the scope of the research study. An account of the most interesting and salient aspects of the participant's experience was created.
Stage 5: Moving to the next case	The process was repeated with each participant's transcript with care taken to ensure that the previous participant's experience did not interfere with the analysis of the participant's experience currently under analysis.
Stage 6: Looking for patterns across cases	Once all the transcripts had been analysed, connections between cases was explored and final themes were identified.

Appendix L: Excerpt of Participant Transcript with Initial Noting and Emergent Themes

Emergent Themes		Initial Noting
Feeling different to others.	1 I: So, first could I just ask you how your...how you've found your training? 2 P: [laughs] Erm, OK [pause], erm...	Up + down process Not wanting to do again - doubt this
Sense of self-identity	3 I: How would you say it's gone? 4 P: It's been like, you know...a real, kind of, <u>up and down process</u> for me, erm. Not	Very difficult
post impacting on present.	5 an easy one and not one, at the moment, that I would want to do again. Although	First year very hard for me.
Feeling inadequate	6 that might be different when I've stopped doing it and in the <u>real world</u> and I'll be	Everyone very drive
Negative Feelings	7 like, "take me back to be a trainee". Erm...I think I found it...god...like, very difficult,	I felt different
	8 particularly at the beginning. The first year was very hard for me, erm, because, I	feeling inadequate previous experience didn't match skills needed.
	9 think, for, sort of, like, cohort reasons. Not just, you know, meeting a bunch of	Really struggled, felt awful.
	10 people who are, you know, all very driven and very friendly and, umm, very. I, how	Found it really stressful.
	11 my perception was, all very similar and I <u>felt a bit different</u> and I...so that was a bit	Supervision was intense
	12 tricky for me, erm and then with work erm, clinically, I'd...when I first started I'd	I was highly anxious
	13 had experience in erm...obviously I hadn't had experience in some areas and had	Good 3rd placement
	14 adult mental health placement and hadn't done any...all my work had been more	Emotionally got better.
	15 kind of erm, you know, I <u>hadn't done any direct work before</u> and now I was sort of	Found my place.
	16 doing direct work in secondary care and I, you know, <u>really struggled</u> with not	Stopped worrying enjoyed friendships
	17 feeling like...like when I look back I, I, I'm sure I wasn't... awful, erm but I felt	Supervisor shared she had confidence in Rachel.
	18 <u>awful</u> ...	↓ Feel confident
	19 I: mmm	↓ Avoided work
	20 P: umm, and...so yeh, and the first, and the second year I had another placement	↓ Stress.
	21 that, erm, was a psychodynamic placement and my supervisor there was lov...you	↓ Avoid stress.
	22 know, nice person but, erm I found that, I <u>found that really stressful</u> as well	
	23 because I think it was she was a psychodynamic worker, she, almost like,	
	24 supervision was quite like, umm...intense, I think...	
	25 I: mmm	
	26 P: and I was, I was highly anxious...	
	27 I: mmm	
"my place"	28 P: ...and, so, but then, I think, second year, so, kind of, got a bit easier in terms of	
Location.	29 emotionally, erm, as I <u>settled in</u> , you know, got to, like, <u>find my place</u> in the cohort.	
Sense of self in relation to others.	30 or <u>stopped worrying if people liked me</u> , or just, sort of, started to enjoy the	
	31 friendships that I had, erm, had a really good third placement in terms of building	
	32 my <u>confidence</u> with my clinical work because my supervisor then was much more	
	33 like, "I'll see you once a week for an hour. I think you're more than"...you know,	
	34 "just get on with it", which was <u>what I needed</u> . Not in a dismissive way, in more in a	
	35 "that-sounds-fine-[Rachel], you-don't-need-to-ask-me-all-the-time" way. Which	
	36 made me, erm...gave me some <u>confidence</u> that I <u>could actually be a psychologist</u>	
Self-belief as psychologist.	37 [laughs]...	
Future.	38 I: mmm	
Sense of self.	39 P: ...erm, so that was good...and then the research I found really hard, erm...cos I'm	
	40 <u>a massive avoider</u> and erm, so I got, I <u>got stressed</u> but my way of dealing with	
	41	

Emergent Themes

Link

You → Personal Therapy

Exposure to others' experiences.

Needing an excuse to have therapy.
Therapy is not justified.

Self blame.

Need to change →
Blaming self for things going wrong in life.

42 stress is to... avoid it and hope it goes away. And then when it comes back, it's even
43 worse...
44 I: mmm.
45 P: Erm, so, that, I struggled with.
46 I: During your training were there times when you thought about having personal
47 therapy as part of that?
48 P: Yeh...well I'd been thinking about having personal therapy way before I started
49 training, erm, not, I say way, you know...[pause]...I think I, when I, sort of,
50 embarked upon this career, I knew enough to, like, think that, erm, that might be a
51 part of it...of the training process...and that would be a part of it that I would be
52 interested in, in, umm, in engaging with and my assistant psychology post before I,
53 umm, began training, um, was with...on, in that post...one of the clinical
54 psychologists was newly qualified from University of Hertfordshire...
55 I: mmm
56 P: ...erm, which is a...which my experience of her, and my colleagues that were
57 from there as, like a, very reflective course, very, erm...yeh, I guess, very, sort of,
58 into you and who you are and what you bring to the process. So, a lot, this person
59 that I worked with had had therapy herself for a long time...How therapy will
60 I: mmm be useful for
61 P: ...and she used to talk about it at work, not...I don't mean the ins and outs, I just
62 mean how, like, a life-changing experience it had been for her and how valuable
63 she'd found it, erm, so I don't know if that was when I first started...I don't think
64 that was when I first started seriously thinking about it. I think I'd been thinking
65 about it already but it was that, sort of, compounded things, I guess. And I was
66 excited when I started training about the idea that this would be an opportunity,
67 almost like an excuse or a reason to have some therapy...
68 I: mmm
69 P: ...erm, or I thought that it would give me an opportunity to find out how to go
70 about it or, erm, who to go about getting it with...
71 I: mmm
72 P: ...that type of thing. So, I've been thinking...I had been thinking about it before
73 training, oh, and I'd had relationships that, I, that, erm [pause]...I, I, I...my
74 memory's not brilliant, which is not very useful for your, this [laughs] but erm, I
75 can recall, like, having arguments in relationships and being, like, thinking I need
76 some, sort of, therapy [laughs], erm, or...just feeling... that, yeh, that I did need to
77 get to know myself better or to, sort of, deal with some things, or to work out...not
78 deal with some things, but perhaps to find out more about, erm, why I was like I
79 was and...how to...how to change really...
80 I: mmm
81 P: ...so that was all before training and, erm, carried on during training. And, yeh, a,
82 a...particularly on my second placement, I had the psychodynamic, erm,

Page stress goes away, but it doesn't.

↓
Struggle.
Therapy as interesting

Started training with thoughts about therapy

A part of the training process.

Training Career as a journey that you embark on - therapy part of that journey.

Another psychologist →

Cause into you Therapy.

Exposure to others' experience or therapy
"life-changing" experience
"Valuable"

Excited about starting therapy → an excuse → Justification.

An opportunity for info.

"Thinking about it."

Memory's not brilliant.

Personal relationship

↓
Arguments

↓
Need to know better

↓
Change.

Scope for self improvement.

2
Blaming self for things going wrong in life.

Emergent Themes	83	supervisor...and it came up quite a lot then...I think she was all, her and, the other.	Nothing
Exposure to me. ideas about therapy.	84	there's another member of the department that was, erm, a <u>psychodynamic</u>	Supervisors talking about the benefits of therapy → exposure to me
Culture / Vibe	85	practitioner as well...and they used to talk a lot about the...benefits of	
	86	therapy...and, erm, I was working with a third year trainee and he was having	
	87	therapy. So, there was a kind of that like, you know, <u>vibe</u> going on there that it was	Vibe ⇒ therapy is the thing to do.
	88	the thing to do.	
	89	I: When...do you recall what you picked up from your supervisor about these	
Me in relation to the culture around me	90	benefits of therapy?	
	91	P: I don't know if there was, I think, because in that placement, I spent so much	emotional
	92	time <u>crying</u> [laughs] and, erm, she would ask questions in supervision like...so this	dealt with a client.
	93	is an example that sticks out in my mind...I was working with a person, an older	
	94	adult so a woman in her 70s or 80s about, erm, err about <u>coping with the stress</u> of	
Boundaries	95	her husband with dementia. And my supervisor was like, "what was her childhood	Block on me asking - do seem appropriate → boundaries.
	96	like?" and I was like "I don't know", like, "I don't want to ask", and she was, like	
	97	[laughs], I don't know, for some reason there was some <u>block on me</u> asking. I think	Resistance in clinical work.
	98	it was just that in my head I was like, "I don't know that...she's never initiated that,	Supervisor invited me to reflect... Supervisors style.
Others initiating / inviting reflections.	99	we've always been talking about her husband and life now" ...and I felt quite weird	
	100	asking. My supervisor, sort of, <u>invited</u> me to reflect upon why I was <u>resistant</u> to	Supervisor gave me ideas about what to expect from therapy.
	101	asking about childhood...	Explore (therapy)
	102	I: mmm	
Others drawing hidden parts of myself out.	103	P: ...and actually there was no, you know, there's nothing, there was no real reason	Me - person to me about me.
	104	there but it was just that, sort of, conversations that we would have during	Was a bit weird ↓ difficult experience.
	105	supervision...	
	106	I: mmm	
	107	P: ...that, you know, she was saying these are, perhaps these are the sorts of things	
	108	that you might <u>explore</u> should you have therapy, erm, I mean that example, it	
	109	wasn't particularly relevant to <u>me</u> but, erm, and she made, umm I guess, a couple of	
	110	comments like, that, where I suppose, you know, interpretations [laughs], I don't	
	111	know...about <u>me</u>).	
	112	I: mmm	
	113	P: ...and, it was a bit weird really but...	
	114	I: So, how did that experience link to you thinking about having therapy?	
	115	P: Erm, well I wouldn't say it was, it wasn't...I didn't decide to have therapy off the	
	116	back of that placement...	
	117	I: mmm	
	118	P: ...it's just another part of the kind of back drop to it, I suppose.	
	119	I: mmmh	
	120	P: When I did decide to have therapy it was long after that. I didn't...that was in my	Started therapy at the end of my second year.
	121	first year and I started therapy at the end of my...second year so it was a whole	
	122	year after that, erm, but it, you know, I guess I'm just, sort of, talking about it	

Emergent themes			
Exposure to no idea of therapy.	123	because it was part of the, erm, <u>my awareness</u> of why or what might be a good	Experiences increased awareness of why therapy might be a good idea.
	124	reason to have it...	
	125	I: So there's something about 'awareness'?	
	126	P: Yeh	
	127	I: mmm	Don't want to be told to have therapy.
Resistant against expectation of therapy → choice	128	P: And erm, I didn't have therapy then for several reasons but it was probably a bit, like, <u>stubbornness</u> cos I think I did feel a bit like it was <u>expected</u> [laughs]. Then I	Stubborn
	129	didn't really, but it still, yeh, it still I guess kind of, erm [pause] was part of my	↓
	130	<u>curiosity</u> about the process, I think, erm...	Expected.
	131	I: Can you say a bit more about that?	Curiosity
	132	P: Just because it was, you know, there or, like, people talking about...their...about	self interest
Can't hide from self.	133	it and I'm interested in, erm, of course I am. I mean, you don't go on to do these	Trainees are interested in themselves.
	134	<u>sort of courses if you're not interested in yourself</u> I don't, I don't think, you know...	Interested in how I can change who I am.
	135	I: mmm	
	136	P: ...so I'm interested in myself, I'm interested in why I am like I am, and I'm	
	137	interested in how I can change that, erm, and in that placement particularly those	
	138	sorts of conversations were going on all the time - about clients and about each	
	139	other and it was just, it was <u>more of a culture</u> and not necessarily directly therapy	
Exposed to the Culture / Vibe.	140	but it was more of a kind of, so I, the therapy that I did go on to have was a dynamic	Culture - talking about selves/clients all the time → exposure.
	141	therapy and so it was just that, sort of, you know, it was just a <u>culture</u> in that	
	142	placement, I guess, that...	
	143	I: mmm	
	144	P: ...that, you know, I enjoyed in that way, as like an interest way, if, erm...	
	145	I: mmm	
	146	P: ...and, of course, I wanted to relate <u>that to myself</u> , like I, you know [laughs], I	Can't hide from self during training
Can't hide from self. move/less. Exposure to idea of therapy	147	don't think, I think <u>most people can't help</u> , you know, you're learning about those	I wanted to relate that to myself.
	148	sorts of things and you're, you know, <u>you're talking to other people</u> about their	Talking to others
	149	experiences and how it effects them, how they are and then you think about what,	↓
	150	you know...me...why my experiences have effected how I am, so, and more, you	Thinking about myself.
	151	know, on the other placement I'd had before then, that was CBT and that was far	
	152	<u>less of an emphasis</u> so I think that's why that placement in particular perhaps...	
	153	I: mmm	
Training not the catalyst for idea but the exercise/trigger to do it	154	P: ...but, as I say, it was, I, you know...it was, it wasn't that...I'd long before decided	It was always a thought.
	155	that I would like to, have, you know <u>it was always a thought</u> ...	Triggered it.
	156	I: yeh	
	157	P: ...but that placement, I think, it was, just <u>triggered it</u> a bit more maybe.	
	158	I: You talked about this idea of an 'expectation' on that placement...	
	159	P: yeh...	
	160	I: ...can you say a bit more about that at all?	
Norms/expectations of culture influencing self.	161	P: I think because, it wasn't, it was, you know, the <u>culture</u> was psychodynamic and	Therapy = enforced in other disciplines
	162	obviously when you do psychodynamic training you <u>have to have therapy</u> erm, so	
	163		

Appendix M: Main Themes and Sub-themes for one Participant

Settling

- Finding ‘my place’
- Physically being in the right place

Timing

- Training as a special time to have therapy
- Waiting for the ‘right time’ – need to be ready
- Past self in relation to current self
- Future self in relation to current self

Need for change/resistance to change

- I need to be different
- Feeling stuck – therapy unsticking me
- Therapy as a personal choice
- Shift in personal view of therapy

Therapy not justified

- I need permission – training as impetus
- Evidence for therapy working
- I don’t have a problem – self as non-therapy-going type
- Feeling unworthy of burdening others with my problems

Exposure/awareness

- To others’ experiences of therapy – evidence of change
- To cultural views of therapy
- Others/training exposing hidden parts of myself
- Being open to therapy exposing hidden parts of self
- Fear of damaged caused by exposing self to others

Boundaries

- Between self and client
- Between self and other trainees/psychologists – privacy –vs- isolation
- Between self and therapist
- Giving parts of self to therapy process

Faith

- In therapy working
- Not clear what therapy does/is
- I can’t do it alone – lack of faith in self